

In this issue

This issue contains two reviews, one on depression and cognitive impairment in older people and one on the psychological evaluation of Samaritan kidney donors. Other sets of papers examine the prevalence and correlates of forms of psychopathology and various aspects of depression.

Geriatric depression and cognitive impairment

In the first paper, Steffens & Potter (pp. 163–175) review a series of clinical issues relevant to co-morbid depression and cognitive impairment in older adults. The authors focus on three areas: (1) the prevalence of co-morbidity; (2) factors associated with persistent cognitive impairments in depression; and (3) assessment and treatment. They found that cognitive impairment is common in depression among older adults, with the consequence that difficulties are more likely to persist. However, the authors conclude that the evidence suggests clinicians can reduce the impact of such complications with a proactive approach to assessment and treatment, which may include both pharmacological and therapeutic interventions.

Psychological evaluation of Samaritan kidney donors

Kranenburg *et al.* (pp. 177–185) report on a systematic review of five studies of the psychological evaluation of Samaritan kidney donors. In all of the studies, the evaluation included a psychiatric or psychological consultation as standard practice. Two major criteria for rejecting donors were identified: psychological instability and motivational issues. The authors conclude that there is a need for further information exchange between centres running donor exchange programmes, so that evaluation criteria can be improved.

Prevalence and correlates of psychopathology

This issue contains four papers on the prevalence and correlates of psychopathology in large samples. In the first, Shankman *et al.* (pp. 187–198) investigated associations between a series of subthreshold psychiatric conditions and their corresponding full syndromes in a sample of 739 young adults and 1744 of their relatives, drawn from the Oregon

Adolescent Depression Project. The authors found that subthreshold anxiety, alcohol abuse, conduct disorder and major depression (at trend level) were associated with their full syndrome equivalents. However, after controlling for co-morbid conditions, only alcohol abuse and conduct disorder remained significant. A number of associations were observed between subthreshold conditions and different full syndromes. The authors conclude that there is a need to broaden the study of subthreshold psychopathology to include multiple disorders.

Zimmerman *et al.* (pp. 199–210) examined the prevalence of DSM-IV Axis I diagnostic co-morbidity in a sample of 2300 outpatients drawn from the Rhode Island Methods to Improve Diagnostic Assessment and Services (MIDAS) project. The authors found a mean number of current disorders of 1.9 and a mean number of lifetime disorders of 3.0. The majority of patients were diagnosed with two or more disorders, with the highest levels of co-morbidity being found for patients with a primary diagnosis of post-traumatic stress disorder or bipolar disorder. The authors conclude that clinicians should assume patients will present with more than one disorder.

Williams *et al.* (pp. 211–220) report findings from the South African Stress and Health Study on the 12-month prevalence and severity of common mental disorders, based on a sample of 4351 adults aged 18 years or over. The 12-month prevalence of any disorder was 17%, higher than that found in other studies in Africa. Of those with a disorder, 26% were classified as severe and 31% as moderately severe. Of these, only 28% were in treatment. The authors conclude that there are high levels of unmet need among people with severe and moderately severe disorders.

Patel *et al.* (pp. 221–228) compared the screening properties of five widely used questionnaires designed to detect common mental disorders (CMD) in a sample of 598 primary-care attenders in India. All questionnaires were found to be highly accurate in identifying CMD, the best being the General Health Questionnaire and the Self-Reporting Questionnaire. All were correlated with each other, although this was weakest for the shortest questionnaires – the Kessler Psychological Distress Scale and the Primary Health Questionnaire. The positive predictive values of the questionnaires, compared with a diagnostic interview, ranged from 51% to 77%.

Depression

Seven further papers examine various aspects of depression. In the first, Rabbitt *et al.* (pp. 229–236) examined the effect of Beck Depression Inventory scores on mental ability over a 4–16 years period in a sample of 5070 volunteers aged 42–93 years. They found that depression scores were associated with overall levels of cognitive performance, independent of potential confounders. The authors further report that these associations held even within ranges below the population average. Depression scores, however, did not affect age-related cognitive decline.

Scheurich *et al.* (pp. 237–246) investigated the impact of motivation on cognitive impairment in major depression by using goal-setting instructions during neuropsychological assessment in a sample of 60 inpatients with depression and 60 matched controls. Without goal setting, depressed patients showed lower baseline performance and lower self-efficacy than controls. With goal setting, there was significant improvement in memory and psychomotor performance, such that results were similar for patients and controls. The authors conclude that cognitive deficits in depressed patients are influenced by motivational shortcomings.

Mitterschiffthaler *et al.* (pp. 247–256) examined the neural correlates, assessed using fMRI, of the emotional Stroop interference effect in major depression (MD) in a sample of 17 subjects with MD and 17 matched controls. Compared with controls, depressed subjects showed greater increases in response times in the Stroop test from neutral to bad words. In fMRI analyses, depressed subjects showed significant engagement of left rostral anterior cingulate cortex (ACC). Rostral ACC activation was also positively associated with latencies of negative words in depressed subjects.

Martens *et al.* (pp. 257–264) investigated the course and predictors of depressive symptoms in the year following myocardial infarction (MI) in a sample of 288 subjects hospitalized for MI. They found that symptoms were stable during the first year and that subjects could be categorized into four groups by severity of depression. Independent predictors of depression were: a cardiac history, prior depression and Type D personality (i.e. negative affect, socially

inhibited). The authors conclude that the findings strongly argue for a need to routinely screen for depression during hospitalization for MI.

Nuyen *et al.* (pp. 265–277) examined the relationship between a series of chronic somatic conditions and GP-initiated care for co-morbid depression in a sample of 991 patients newly diagnosed with depression. The authors found that those with pre-existing ischaemic heart disease or arrhythmia were less likely to have any depression care initiated by their GP than those with no chronic somatic condition. No other conditions were associated with GP-initiated care. The authors conclude that there is a need to develop interventions to support GPs in managing co-morbid depression in those with heart disease.

Richards *et al.* (pp. 279–287) report findings from a Phase II patient-level randomized controlled trial (RCT), nested within a cluster RCT, of collaborative care for depression in UK primary care. The aims were to assess the effectiveness of collaborative care and to determine the optimum design for a Phase III trial. In a sample of 114 subjects (41 intervention group; 38 patient-randomized control group; 35 cluster-randomized group), the authors found a modest to large effect for collaborative care on depressive symptoms. This effect was probably partly mediated through the organizational aspects of the intervention, and the authors conclude that a Phase III cluster RCT would provide the most robust test of these initial effects.

In the final paper in this issue, Uher *et al.* (pp. 289–300) examined the psychometric properties of three commonly used depression rating scales [the 17-item Hamilton Depression Rating Scale (HAMD-17), the Montgomery–Asberg Depression Rating Scale (MADRS), and the Beck Depression Inventory (BDI)] in a sample of 660 adult patients with unipolar depression. The authors found that both the MADRS and the BDI provided internally consistent but mutually distinct estimates of severity. The HAMD-17 was not found to be internally consistent. The authors conclude that the MADRS and BDI can be recommended as complementary measures of depression severity.

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