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Prevalence of recurrent brief depression in primary care

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Abstract Descriptions of mentally ill inpatients have strongly influenced current classifications of mental disorders. Primary care patients may therefore present a substantially different pathology. Some diagnoses, infrequent in psychiatric settings but common in the general population or in primary care, have been described, such as the concept of recurrent brief depression (RBD) proposed by Jules Angst. RBD refers to frequent but short-lasting (usually only a few days) severe depressive episodes. In parallel with a study organized by the World Health Organization aimed at defining the psychological disorders encountered in primary care, we investigated the prevalence of RBD, its severity, and comorbidity with major and well-defined disorders using a structured interview (CIDI). The current prevalence of RBD in a general practice population was found to be about 10%. The average duration of the episodes is 3–4 days. Our results confirm the severity of this disorder; in particular, a history of suicide attempts is frequent (23.3%). Among RBD patients, 26% do not present any other psychiatric disorder. When a comorbidity is reported, depressive episodes (lasting at least two weeks, according to ICD-10) and generalized anxiety disorder are the main associated disorders. Our results are in favor of the existence of RBD as a separate and original nosological entity.

Key words Recurrent brief depression · Primary care Epidemiology

This study was conducted in parallel with the WHO project on Psychological Problems in General Health Care. A list of the collaborating investigators and information on this study can be found in volumes of the report of the project on Psychological Problems in General Health Care, WHO, Geneva

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1 Introduction

In the history of psychiatry, the field of depression has always been subject to various definitions. At the end of the 19th century, Kraepelin described an original nosological entity called “manic-depressive insanity,” which he considered to be of biological origin and to which he opposed “non-endogeneous” depressive disorders. Subsequently, various non-endogeneous depressions have been described with little consensus about their definitions.

In the 1970s, diagnostic criteria were introduced, initially for the purpose of favoring “objectivity instead of etiological non-demonstrated hypothesis” (Feighner et al. 1972). The classification of depressions then underwent a significant change, stressing the opposition between primary and secondary depressions. A few years later, another classification was proposed: the Research Diagnostic Criteria (Spitzer et al., 1978). Its purpose was to facilitate communication between researchers and to define more homogeneous groups for therapeutic studies. The concept of “major” depression was introduced to underline the importance of severe cross-sectional clinical features.

Over the past few decades, operationalized criteria for psychiatric diagnosis have expanded into various standardized systems (American Psychiatric Association 1980, 1987; World Health Organization 1976, 1992). Although the criteria for depression vary among these diagnostic systems, the definition of the so-called “major depressive episode” is always based on a syndromic criterion, with a specified number of symptoms required, and on a duration criterion. These definitions are based mainly on clinical data of depressed patients recruited in specialized inpatient settings. The relevance of these definitions for subjects selected from nonpsychiatric settings has not been well established and has even been disputed (Cooper 1990).

Primary care patients may present disorders of milder severity and with a qualitatively different symptomatic pattern. Therefore, diagnoses either unique to primary

care or infrequent in psychiatric settings have been described, such as the minor depression discussed in the DSM-IV Options Book (American Psychiatric Association 1991), or the mixed anxiety and depressive disorders introduced in the ICD-10 (World Health Organization 1992). Recently, based on the data observed in the Zurich cohort study (Angst et al. 1985), Angst proposed the concept of recurrent brief depression (RBD). He found that among young adults from the general population, a substantial proportion fulfill all the criteria for major depression according to current classification systems, except for duration. In line with the hypothesis of a continuum from normal sad mood to pathological depression, Angst proposed a new categorization based exclusively on the ground of the duration of such recurrent depressive episodes.

In fact, subjects with recurrent brief depression meet the symptomatic criteria for a major depressive episode according to DSM-III-R, but the episodes usually last 2–4 days, with a high recurrence rate (nearly every month over a 1-year period). As regards symptomatology, association with somatic and psychiatric disorders, age at onset, family history, longitudinal course, and level of impairment, they were found to suffer as much as patients meeting the duration criterion for major depressive episode. This suggests that RBD constitutes a valid subtype of affective disorder (Angst et al. 1990).

Others authors have described some types of depression very similar to RBD. Montgomery has found in prospective placebo-controlled studies that brief depressive episodes were risk factors for subsequent suicide attempts in a group of repeated suicide attempters who did not meet the criteria for major depression (Montgomery et al. 1983). He unsuccessfully treated them with a 5-HT reuptake inhibitor (Montgomery et al. 1992).

More information is needed before giving an operational definition of these recurrent brief depressions and recognizing their validity. Toward this end, it may be useful to explore the existence and the relevance of this diagnosis in primary care before disentangling it from other depressive and anxiety states.

In parallel with a study organized by the World Health Organization (WHO), which aimed to define the psychological disorders encountered in primary care (Üstün et al. 1993), we investigated the prevalence of RBD, its severity, and its comorbidity with major and well-defined disorders. The WHO project on Psychological Problems in General Health Care is a transcultural investigation carried out in 15 settings, including Brazil (Rio de Janeiro), Chile (Santiago), Germany (Berlin, Mainz), France (Paris), Greece (Athens), India (Bangalore), Italy (Verona), Japan (Nagasaki), the Netherlands (Groningen), Nigeria (Ibadan), the People's Republic of China (Shanghai), Turkey (Ankara), the United Kingdom (Manchester), and the United States of America (Seattle). It was designed to explore forms and rates of psychological disorders manifested in general health care settings in different cultures, to further develop methods for the study of characteristics of such disorders and their course in different

settings, and to lay the scientific groundwork for future international research in this area.

Because of its specific organization of health services based on free medical care and free access, general practitioners in France present a recruitment representative of the population seeking medical care. The aim of this paper is to report the preliminary results of the French center on the prevalence in primary care of RBD as defined by Angst, the severity of this disorder, the associated suicide risk, and the comorbidity with other diagnoses. All diagnoses presented are made according to ICD-10, since RBD was introduced within this classification. The disability, health consumption, and treatment strategies linked to RBD will be described in another paper.

2 Methods

Following is a summary of the methodology. Further details on the study, its goals, methods, and initial results regarding implementation and feasibility are described elsewhere (Sartorius et al. 1993).

After a preparatory phase, a pilot study was carried out at each center to test the feasibility of all procedures to be used in the main study and to provide information about the primary care settings to be included in the main study. In France, these studies have been carried out in general medical settings. The research employed a two-stage finding procedure. During the first stage, a brief general health questionnaire consisting of 12 items (GHQ-12; Goldberg et al. 1988) was administered by a research assistant to all patients aged 18–65. GHQ-12 was chosen because it permits the identification of patients at high risk of becoming psychiatric “cases” from a score threshold. The exclusion criteria were: too ill, lives too far away, no fixed address, not a medical consultation, language problem other communication problem. Patients were selected for the second stage interview (SSI) through a stratified random sampling. All patients with high GHQ scores (7–12), 35% of patients with moderate GHQ scores (4–6), and 10% of patients with low GHQ scores (0–3), were selected for the SSI.

Second-stage interviews were carried out as soon as possible after the first-stage screening (within one week) on those who had given their informed consent. The SSI included various instruments. Detailed demographic information, primary reason for contact, pathway to care, chronic diseases, medications received, and main psychiatric diagnoses according to DSM-III-R and ICD-10 were assessed with the primary care version of the Composite International Diagnostic Interview (CIDI) (World Health Organization 1991). This structured diagnostic interview allows for both dimensional and categorical measures of symptoms. The disability was assessed by the Social Disability Schedule (SDS), a semi-structured assessment of occupational disability (Wiersma et al. 1990) and by a Brief Disability Questionnaire (BDQ) adapted from the Medical Outcome Study disability questionnaire (Stewart et al. 1988; Ware et al. 1992). Overall health was rated by

Table 1 Diagnostic criteria used for recurrent brief depression

<ul style="list-style-type: none"> • Dysphoric mood or loss of interest • Duration of less than 1 week • Nearly every month over 1 year • At least four of the following symptoms: <ul style="list-style-type: none"> Poor appetite Insomnia or hypersomnia Fatigue Psychomotor retardation Loss of interest Feelings of worthlessness, guilt Diminished ability to concentrate Thoughts of death 	<ul style="list-style-type: none"> • At least one of the following (impairment): <ul style="list-style-type: none"> Has been hospitalized Has told a doctor Has told any other professional Has taken medication more than once Has kept from working or seeing friends or relatives Life, work, or activities perturbed
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both patients and practitioners (on five-points forms). The latter were asked to rate all those selected for SSI. Thus, information concerning recognition of psychological disorder and prescription of treatment by general practitioners were collected. No specific therapeutic was recommended to the general practitioners in charge of the patients. Patients were followed up after 3 and 12 months in order to assess the 1-year outcome and the stability of their conditions.

A full set of all the forms for all the phases of the study was provided to each of the centers. Instruments have been translated from and back into the original English version. Research assistants were trained to use the standardized clinical and social assessments during a 1-week training session. Reliability among raters at each center and among centers has been assessed and improved.

With the agreement of J. Angst on the diagnostic criteria (Table 1), a section on recurrent brief depression was added onto a CIDI format.

These diagnostic criteria are identical to those for major depression with respect to mood and number of symptoms, but the length requirement for the depressive episodes has been reduced to less than 1 week. Additionally, such episodes must have recurred nearly every month over the last year. As with other research diagnostic criteria, the definition of RBD also requires impairment. We identified and excluded the patients presenting brief episodes of depression linked only to menstruation periods. The RBD section was explored after the Depression section in the second-stage interview.

To those who were recognized as presenting RBD by the CIDI format interview, an additional questionnaire was sent a few months after the second-stage interview. This permitted the collection of more information about the average length of the episodes, age at onset, number of episodes during the last year, number of months without depressive symptoms during the last year, and seasonality. We obtained 67% of responses to this questionnaire after two requests.

Analysis

Because of the two-stage sampling procedure used in the study, we oversampled patients who had scored highly on the GHQ-12. Therefore, patients who completed the SSI

were more likely to suffer from a psychological disorder. When generalizing the findings from the second-stage sample to cover all general health attenders, it was consequently necessary to adjust for these varying probabilities of being selected for interview. Additionally, the response rates among those sampled for SSI also varied from one GHQ stratum to another, and between the sexes. The weights applied to each subject in the second sample are therefore based on the observed numbers of patients screened (i.e. who completed GHQ), sampled for interview (i.e. who were selected and approached for interview) and who completed the interview, both within each GHQ stratum and by sex.

This weighting procedure was used for prevalence estimations, but not when analyzing relationships between variables from the second-stage interview. Categorical variables were computed by chi-square test, or by Fisher's exact test when small values were expected.

3 Results

Sample selection

Between February and December 1991, 2699 patients were approached. Among them, 548 were ineligible and 55 refused to complete the brief questionnaire. Therefore, we gathered 2096 GHQ-12 during the first stage. In this initial sample, 61.9% of the patients has a low, 22.0% a moderate, and 16.1% a high GHQ score. The results of the sampling procedure according to sex and GHQ strata are presented in Table 2.

The stratified random sampling on the GHQ-12 selected 654 eligible patients for the second-stage interview. Because of refusals (24.8%) or technical impossibilities (13.7%), 405 SSI were completed. The second-stage sample comprises 7.1% of the low GHQ scores found in the initial sample, 25% of the moderate scores, and 58.6% of the high scores.

Prevalence of recurrent brief depression

The prevalence rates of depressive disorders stratified by sex are presented in Table 3.

Table 2 Response rates according to GHQ by sex strata [Screened = first-stage sample (GHQ completed), Sampled = patients eligible for second stage interview, Interviewed = second-stage sample]

		Screened (n)	Sampled (n)	Interviewed (n)	SSI Non- completion rates (%)
<i>Male</i>					
Low GHQ score	(0–3)	751	81	55	32.1
Medium GHQ score	(4–6)	238	81	63	22.2
High GHQ score	(7–12)	122	122	76	37.7
<i>Female</i>					
Low GHQ score	(0–3)	547	57	37	35.1
Medium GHQ score	(4–6)	222	97	52	46.4
High GHQ score	(7–12)	216	216	122	43.5
Total		2096	654	405	38.1

Table 3 Prevalence of depressive disorders in primary care (ICD-10)

	Males		Females		Total	
	n	Prevalence ^a (wt %)	n	Prevalence ^a (wt %)	n	Prevalence ^a (wt %)
Current depressive episode	46	9.5	87	18.7	133	13.8
Lifetime depressive episode	67	17.8	133	46.9	200	31.5
Current dysthymia	11	2.9	17	4.3	28	3.6
Lifetime dysthymia	28	8.7	37	13.4	65	10.9
Current RBD	32	7.5	41	12.8	73	9.9

^a Prevalence rates are estimated by applying weights to each individual second-stage patient value

Among the 405 patients who were interviewed, 73 fulfill formal criteria for a current diagnosis of RBD. This corresponds to a current prevalence of 9.9% in primary care (7.5% in males, 12.8% in females). The prevalence rates of current Depressive Episode (DE¹) and current dysthymia obtained from the same sample are 13.8% and 3.6%, respectively. The lifetime prevalence rates are 31.5% for DE and 10.9% for dysthymia. The lifetime prevalence of RBD was not assessed.

The higher female-to-male sex ratio is observed in DE (2.6 for lifetime and 2.0 for current DE) and is still 1.7 for RBD and 1.5 for dysthymia.

The mean age of patients presenting RBD is 38.3 years (SD = 11.1) with a range from 18–62 years. This mean age at time of interview do not differ significantly from the observed mean age of patients with DE (36.7 years, SD = 11.2), nor of patients in the sample without depressive disorder (36.9 years, SD = 11.6).

Among RBD patients, 31.5% are married, 41.1% were never married, and the remaining are separated or divorced. About the same proportion of DE patients are married (30.8%), while in nondepressed patients this proportion is significantly higher (50.4% married, $P < 0.05$).

The RBD patients in our sample are typically employed (75.3%) and have a relatively high level of education (61.6% completed high school). The same figures are observed in DE patients and in patients without depressive disorder.

Severity of recurrent brief depression

The mean GHQ-12 score is 6.1 in RBD patients, 7.7 in DE patients, and 1.2 in patients without well- or ill-defined diagnosis.

Among RBD patients, 49.3% consider their overall health as fair or poor. Overall health was rated as fair or poor in 58.8% of DE patients and in only 2.4% of patients without well- or ill-defined diagnosis.

General practitioners identified 35.0% of RBD patients as having a moderate or severe psychological disorder, 39.5% of DE patients, and 3.6% of patients without well- or ill-defined diagnosis.

Current comorbidity among depressive disorders

According to the RBD definition, when a patient presents frequent brief episodes of depression, he or she may also suffer from longer depressive episodes and possibly meet the criteria for DE. Among the 73 patients identified as having a RBD, 30 also met the criteria for a current DE and 14 for both DE and dysthymia. In the remaining 29 patients, RBD is the single depressive condition.

The rates of the different possible associations among depressive disorders, according to sex, weighted to the initial sample of consecutive attenders in general practice are shown Table 4. The categories are mutually exclusive, since patients were classified according to the presence or absence of each of the three diagnoses.

¹ By convention, we use the expression “DE” to refer to the ICD-10 definition of depressive episodes lasting at least 2 weeks.

Table 4 Current comorbidity within depressive disorders

	Males		Females		Total	
	<i>n</i>	Prevalence ^a (wt %)	<i>n</i>	Prevalence ^a (wt %)	<i>n</i>	Prevalence ^a (wt %)
Any current depressive disorder	61	14.4	104	26.2	165	19.9
RBD only	13	3.5	16	7.0	29	5.2
DE only	24	5.1	54	11.0	78	7.9
Dysthymia only	2	1.4	1	0.4	3	0.9
Both RBD and DE	13	2.9	17	3.8	30	3.3
Both DE and Dysthymia	3	0.4	8	1.9	11	1.1
Both RBD and Dysthymia	0	—	0	—	0	—
RBD and DE and Dysthymia	6	1.1	8	1.9	14	1.5

^a Prevalence rates are estimated by applying weights to each individual second-stage patient value

Table 5 Current comorbidity of depressive disorders with other psychiatric conditions (ICD-10)

	No depressive disorder (<i>n</i> = 240) %	RBD (<i>n</i> = 29) %	DE (<i>n</i> = 78) %	RBD + DE (<i>n</i> = 44) %
No other diagnosis	70.0	44.8**	38.5***	13.6**
Panic disorder	0.8	3.4	— ⁺	9.1*
Generalized anxiety disorder	7.5	37.9**	30.8***	50.0**
Agoraphobia	2.1	—	5.1	6.8
Neurasthenia ^a	4.6	24.1**	23.1****	54.5**
Somatization disorder	0.4	— ⁺	6.4**	18.2**
Pain disorder	14.2	34.5*	21.8	34.1*
Alcohol ^b	9.6	20.7	17.9*	22.7*

^a For analysis purposes, the exclusion criteria for neurasthenia concerning depressive and anxiety disorders was not used
^b "Alcohol" refers to alcohol dependence or harmful use of alcohol according to ICD-10
 vs "No depressive disorder":
 * = $P < 0.05$, ** $P < 0.001$;
 vs "RBD + DE": + = $P < 0.05$,
 ** $P < 0.001$; "RBD" vs "DE":
 all comparisons NS

The current prevalence of any depressive disorder is found to be 19.9% (165 of 405 patients interviewed). The current prevalence of diagnoses not associated with any other depressive condition is 5.2% for RBD, 7.9% for DE, and 0.9% for dysthymia. The current prevalence of the association "RBD + DE" (with or without dysthymia) is 4.8%. Among these patients, 38.1% had RBD at least 1 year after DE, 4.8% during the same year, and 57.1% before DE. Association of RBD and dysthymia without DE was not found.

Comorbidity of depressive disorders with other psychiatric conditions

Current comorbidity of RBD and DE with other psychiatric conditions are presented in Table 5. The frequencies of the different associations are given for three subtypes of depressive disorders: RBD without other depressive disorder; DE without other depressive disorder; and RBD + DE. These frequencies are compared to those observed in patients without current depressive disorders. The "RBD + DE" group includes the 14 comorbid dysthymic patients.

Among the patients presenting RBD not associated with other depressive conditions, 44.8% do not meet criteria for other diagnoses. The weighted prevalence rate of "pure" RBD is 2.6% of our initial sample.

Diagnoses more frequently associated with RBD are generalized anxiety disorder (37.9%), pain disorder (34.5%), and neurasthenia (24.1%). These disorders are signifi-

cantly more frequent in this group than in patients without depressive disorders.

The pattern of comorbid nondepressive diagnoses in DE patients is similar to that of RBD patients, with the addition of incidences of association of 6.4% with somatization disorder and 5.1% with agoraphobia. When RBD and DE are associated, a third diagnosis is more likely (86.4%). comorbidity with neurasthenia is higher (54.5%), to which group comorbidity between DE and panic disorder is restricted (9.1%), while panic disorder is presented by 3.4% of RBD patients.

Frequency and seasonality

The recurrence criterion proposed by Angst stresses that episodes must recur nearly every month over the space of 1 year. Of our 73 RBD patients, 60 answered positively to this question in the CIDI interview and 13 admitted to having had frequent episodes but not quite every month. This latter subgroup does not differ from the other RBD patients with respect to sex mean age, or severity of diagnosis.

In addition, of the 49 patients who responded to the questionnaire mailed to the 73 RBD patients after the second-stage interview, 47% reported more than 10 episodes of brief depression during last year, 37% less than 10 episodes, and 16% were unable to answer the question. For 65% of these 49 patients, the duration of the longest depression-free period was less than 2 months.

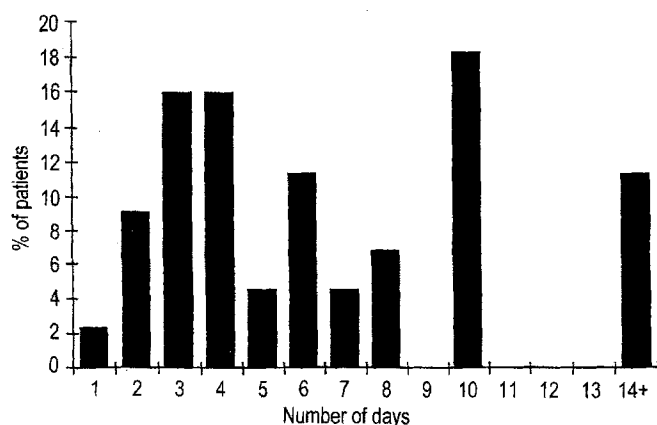


Fig. 1 Distribution of the average length of depressive episodes over 1 year in RBD patients ($n = 44$)

With respect to seasonality, 59% identified the seasons as an influence on the frequency of their episodes. However, the sample size ($n = 49$) did not permit identification of a particular season.

Duration

A total of 44 patients responded to the question concerning the average duration of RBD episodes. The distribution of the average length of depressive episodes during the past year is presented in Fig. 1.

The median of the distribution is 5 days. Most of the patients (70.4%) report an average length of depressive episode of between 1 and 8 days. A first peak is found around 3–4 days and applies to 31.8% of the patients. A second peak at 10 days applies to 18.2% of the patients. Obviously, patients grouped in this class may present an average length of depressive episode of 1–2 weeks. Of these, 62.5% have also experienced at least one DE during the past year. Finally, 11.4% of RBD patients reported an average episode length of 2 weeks or more. All presented at least one DE during the past year.

Suicide attempts

The frequency of a history of suicide attempts in patients with RBD, DE, other ICD-10 diagnoses, and no current diagnosis is presented in Table 6 (unweighted percentages). The estimated risks, calculated from 2X2 tables, are presented for each diagnostic subgroup.

A similar frequency of a history of suicide attempts is observed in RBD and DE patients (23.3%). RBD patients are more likely to have a history of suicide attempts than are non-RBD patients (relative risk ratio = 1.93). This ratio does not differ significantly from the relative risk observed in DE (2.44). No increase in relative risk is observed in nondepressive well-defined ICD-10 disorders, despite the presence of a 13.3% incidence of a history of suicide attempts. This rate is substantially higher than in patients without psychiatric diagnosis (4.8%).

4 Discussion

While severe (major) or chronic (dysthymic) depressions are clearly defined, there is a lack of operational definitions for subthreshold forms in term of severity (minor depression), symptomatic pattern (for instance atypical depression or thymasthenia), or duration (RBD). The aim of this paper was to determine whether RBD exists in primary care and, if yes, to describe its severity and comorbidity with other psychiatric disorders.

We found that 9.9% of consecutive patients consulting in primary care met criteria for depressive episodes lasting at least 1 week and recurring almost every month. This result is comparable to that obtained by Angst in his population of 28-year-old adults (1-year prevalence rate of 7.2%, whether or not RBD was associated with other disorders), and confirms the formal existence of this condition. The mean age of primary care patients with RBD is 38 years and the female-to-male sex ratio is 1.7.

In our sample, the average duration of depressive episodes was found to be 3–4 days for patients presenting RBD as a single depressive condition. When RBD is associated with DE, the average duration is obviously longer. This result emphasizes the appropriateness of the choice of “less than 1 week” for the RBD duration criterion instead of “less than 2 weeks”.

In line with Angst’s proposal, ICD-10 criteria require a minimum prior frequency of nearly one episode per month for over 1 year. This regularity of episodic occurrence has been contested by Montgomery, who found in a sample of patients suffering from severe RBD that the intervals between the episodes vary markedly among individuals and also within the same individual (Montgomery et al. 1989). Despite obvious biases in data collection [different forms of questionnaires used, high nonresponse rate to the posted questionnaire (33%)], our results are in agreement with those of Montgomery: 35% of our RBD

Table 6 Previous history of suicide attempts according to diagnostic status

	RBD ($n = 73$)	DE ($n = 133$)	Non- depressive ICD-10 Δ G ($n = 38$)	No disorder ($n = 147$)
History of suicide attempts (%)	23.3	23.3	13.3	4.8
Relative risk ratio	1.93	2.44	0.93	0.25
(95% confidence interval)	(1.16–3.21)	(1.51–3.93)	(0.40–2.18)	(0.11–0.53)

patients have experienced "free intervals" of longer than 2 months during the past year. In addition, more than half of our patients reported a seasonal occurrence of RBD episodes, although no specific seasonal pattern emerged. Further studies are needed that reconsider the recurrence criterion accepted by the ICD-10.

The severity of RBD is comparable to that associated with DE. Apart from the number of symptoms required by the diagnostic definition, we found no difference between RBD and DE in terms of indicators such as GHQ mean score or severity as rated by patients or physicians. Moreover, RBD appears to represent an important risk factor for suicide attempts, comparable to that associated with DE. In our sample, the frequency of a history of suicide attempts is the same for RBD as for DE (23.3%). This result is comparable to that obtained by Angst from a younger general population sample (19.0%).

According to Angst, RBD constitutes a subtype of depressive disorder with a specific clinical course. Therefore, association with depressive episodes lasting more than 2 weeks may exist. In our sample, we found that 44 of 73 RBD patients also present a current DE. The current prevalence in primary care of such "combined depression" is 4.8%.

Regarding the time sequencing of both diagnoses, our results confirm those of Angst: RBD occurs before DE in only 57.1% of cases. Very few patients reported the onset of both in the same year. Therefore, RBD should not be considered a milder form of depression preceding a longer and more severe disorder.

With respect to dysthymia, as well, our results support Angst's thesis that RBD should be considered a distinct condition. Only 14 of 73 patients manifested a chronic depressive state. In fact, subjects with RBD reported having depressions of short duration, even when such moods recur every month.

Depressive states are often associated in the literature with other psychiatric disorders, in particular with anxiety disorders (Regier et al. 1990; Angst et al. 1990). Our results confirm these findings: DE is frequently associated with other disorders. We also found such comorbidity for RBD, especially with generalized anxiety disorder (37.9%) and pain disorder (34.5%). This latter result should be relativized due to the particular setting in which patients were recruited. Nevertheless, pain disorder is significantly less frequent in patients without depressive disorder than in those with RBD.

"Combined depression" (i.e. DE + RBD) is more frequently associated with other psychiatric disorders than are single depressive conditions. Only 13.6% of these patients have no other diagnosis. It is noteworthy that panic disorder is significantly more frequent in patients presenting both depressive diagnoses (9.1%) than in those without any depressive disorder (0.8%) or in DE patients (0%).

In 17.8% of RBD patients, RBD is not associated with any other disorder. In comparison, 22.6% of DE and 8.9% of GAD cases are found in the same sample to be "pure" conditions. The current prevalence rate of "pure" RBD in primary care is 2.6%.

These results are in favor of the existence of RBD as a separate and original nosological entity. Further data from our study – such as impairment and disability linked to RBD, symptomatic profile, and recognition and prescribed treatment by general practitioners – will be presented elsewhere. Furthermore, the results of the 12-month follow-up will enable us to explore the evolution of this disorder in terms of stability.

Various questions still remain unanswered, mainly the place of RBD in bipolar disorders, especially in the rapid cycling types, and the relationship between RBD and personality disorders, in particular borderline personality. Little is known also of the biological features of this disorder or possible specific treatment. Montgomery tried to treat such patients but without success due to population bias or inappropriate treatment. However, an original treatment must certainly be found that would take into account the specific features of this disorder, that is, the briefness of the episodes and the frequency of their occurrence. This last point is important, since the recognition of a new disorder without specific treatment is useless for patients.

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