***CORR* Insights®: Abbreviated Psychologic Questionnaires Are Valid in Patients With Hand Conditions**

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Where Are We Now?

In 1995, Sullivan et al. [8] developed a 13-item Pain Catastrophizing Scale (PCS) to evaluate three dimensions of catastrophizing: rumination (“I cannot stop thinking about how much it hurts”), magnification (“I worry that something serious may happen”), and helplessness (“It is awful and I feel that it overwhelms me”).

In 1999, Spitzer, et al. [7] developed the Patient Health Questionnaire (PHQ), a nine-item, self-administered version of the Primary Care Evaluation of Mental Disorders to diagnose five of the more common types of mental disorders: depressive, anxiety, somatoform, alcohol, and eating disorders. The DASH questionnaire was developed jointly

by the Institute for Work and Health and the American Academy of Orthopaedic Surgeons [3]. This self-reported, 30-item questionnaire measures physical function and symptoms in patients having one or several musculoskeletal disorders of the upper limb. A shortened, 11-item version was subsequently developed and validated [3].

In 2002, Salkovkis et al. [6] validated the short form of the Health Anxiety Inventory (SHAI), an 18-item list used to differentiate people suffering from health anxiety (hypochondriasis) from those who have actual physical illness, but who are not excessively concerned about their health.

These various validated self-reported outcome measures require a fair amount of patient time and compliance. Bot and colleagues use shortened forms of the PCS and SHAI in an attempt to minimize the time required by the patient to complete the forms. Bot and colleagues surmise that by using these questionnaires, clinicians may have the ability to identify patients who could benefit from psychological support.

Where Do We Need to Go?

The authors concluded that the shorter versions of the PCS and SHAI had sufficient content, construct convergent validity, and criterion validity. There were some small differences (mean scores and floor and ceiling effects) between the shorter and longer versions of these questionnaires, but the authors found that the differences were not clinically significant enough to outweigh the advantage of decreasing the responder burden. The limitations of the current study included a small patient population (164 patients), missing data, use of the same cohort of patients from a previous study when creating the shorter versions of the questionnaire, and a 28% patient decline rate to

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participate in the study. In the development of the PHQ, two large studies, enrolling 6,000 patients, were used to validate the questionnaire.

An association between psychological symptoms and health-related quality of life has been shown in previously published studies [1, 4, 5]. Similarly, there is a high incidence of psychiatric disorders in patients with chronic work-related musculoskeletal pain disability [2]. The ability to identify and counsel patients with psychological disorders should help us care for these patients, whose situations call for management of more than just the musculoskeletal complaints. The development of shortened, validated, patient and physician friendly psychological questionnaires could be very helpful.

How Do We Get There?

I commend the authors for their attempt to develop shortened versions of psychological questionnaires. This study, with a relatively small cohort, is a good start in developing patient-friendly psychological questionnaires. Similar studies will need to be performed to determine if both the standard and shortened versions of these psychological questionnaires are valid not only in upper extremity patients but in all orthopedic patients. Large confirmatory studies are ultimately needed to test the validity and clinical utility of these questionnaires. Finally, after these patients with psychological needs are identified, we need to

look for interventions that can mitigate the impact of psychological disorders on the overall level of disability in these patients.

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