Depressive Disorders in Different Cultures

including the WHO Schedule for Standardized Assessment of Depressive Disorders and a companion glossary

World Health Organization Geneva

DEPRESSIVE DISORDERS IN DIFFERENT CULTURES

Report on the WHO Collaborative Study on Standardized Assessment of Depressive Disorders

N. Sartorius, H. Davidian, G. Ernberg, F. R. Fenton, I. Fujii, M. Gastpar, W. Gulbinat, A. Jablensky, P. Kielholz, H. E. Lehmann, M. Naraghi, M. Shimizu, N. Shinfuku, R. Takahashi

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The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this organization, which was created in 1948, the health professions of more than 155 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

By means of direct technical cooperation with its Member States, and by stimulating such cooperation among them. WHO promotes the development of comprehensive health services, the prevention and control of diseases, the improvement of environmental conditions, the development of health manpower, the coordination and development of biomedical and health services research, and the planning and implementation of health programmes.

These broad fields of endeavour encompass a wide variety of activities, such as developing systems of primary health care that reach the whole population of Member countries; promoting the health of mothers and children: combating malnutrition: controlling malaria and other communicable diseases including tuberculosis and leprosy; having achieved the eradication of smallpox, promoting mass immunization campaigns against a number of other preventable diseases; improving mental health; providing safe water supplies; and training health personnel of all categories.

Progress towards better health throughout the world also demands international cooperation in such matters as establishing international standards for biological substances, pesticides and pharmaceuticals; formulating environmental health criteria; recommending international nonproprietary names for drugs; administering the International Health Regulations; revising the International Classification of Diseases, Injuries, and Causes of Death; and collecting and disseminating health statistical information.

Further information on many aspects of WHO's work is presented in the Organization's publications.

Collaborators and acknowledgements

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Basle (Switzerland)
University Psychiatric Clinic, Basle; and Cantonal Psychiatric Hospital, Weissenau.
Dr P. Kielholz (*Chief Investigator*), Dr M. Gastpar, Dr G. Hole

Montreal (Canada)
Department of Psychiatry, McGill University; *Douglas Hospital Centre*; *and Montreal General Hospital.*
Dr H. E. Lehmann (*Chief Investigator*), Dr F. R. Fenton, Dr R. Lajoie, Dr S. Ang, Dr R. Yassa

Nagasaki (Japan)
Department of Neuropsychiatry, Nagasaki University School of Medicine.
Dr R. Takahashi (*Chief Investigator*), Dr I. Fujii, Dr Y. Sakurai, Dr T. Yuzuriha

Teheran (Iran)
Department of Psychiatry, Roozbeh Hospital.
Dr H. Davidian (*Chief Investigator*), Dr M. Naraghi

Tokyo (Japan)
Department of Psychiatry, Jikei University Hospital.
Dr N. Shinfuku (*Chief Investigator*), Dr K. Hasegawa, Dr M. Shimizu

Geneva (Switzerland)
Division of Mental Health, World Health Organization.
Dr N. Sartorius (*Principal Investigator*), Dr A. Jablensky (*Chief Headquarters Investigator*), Mr W. Gulbinat, Mrs G. Ernberg

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Introduction

Each year at least 100 million people in the world develop clinically recognizable depression and for several reasons the number is likely to increase (Sartorius, 1979). For one reason, life expectancy is increasing in most countries and both the absolute numbers and the proportions of people at risk of developing depression are accordingly also increasing. For another, more people are now living in a rapidly changing social and physical environment that often gives rise to acute or prolonged psychosocial stress and may lead to depressive reactions. At a time when traditional protective mechanisms of social groups are breaking down and many people are exposed to the unsettling effects of uprooting, family disintegration, and social isolation, the prevalence of depressive disorders arising as a response to stressful psychosocial factors (Brown & Harris, 1978) is likely to increase. A third reason is that there is now an increase in morbidity from chronic cardiovascular diseases, collagen diseases, gastroenteric diseases, and cerebrovascular and other neurological disorders, and these have been shown to be associated with depressive reactions in as many as 20% of all cases (Sartorius, 1976). If the prevalence of these organic disorders continues its upward trend (which is likely, with the increase in longeval populations) an increase in the frequency of somatogenic depressive disorders must also be expected. Whether this increase will be offset by fewer cases of somatogenic depression associated with acute physical illnesses—such as infectious diseases—cannot be determined at present. A fourth major reason for the predicted increase in depressive disorders is the greatly increased use of a variety of medicaments and alcohol (Mullinger et al., 1978; Craig & van Natta, 1978). Certain drugs whose consumption is now steadily growing are known to precipitate or exacerbate depression; among them are sedatives and tranquilizers, antihypertensive drugs, and various hormone preparations.

There are thus several reasons to justify the prediction of a genuine increase in the prevalence of depressive disorders. However, true prevalence often affects planning in health less than impressions ("apparent prevalence") do; in the case of depression there are good grounds for believing that the apparent prevalence will also show an increase. More patients suffering from depression are at present likely to seek treatment, and the invisible part of the

"iceberg" of depressive illness in the community which, according to Shepherd (1979), comprises up to 98% of all cases, may thus be reduced. Physicians are showing a greater readiness to diagnose depression, probably because treatment is now more likely to be successful. New diagnostic concepts, such as that of masked depression, are gaining wider acceptance and their use is adding to the statistics of depression cases that would not have been so classified previously (Kielholz, 1979). In many of the developing countries that are becoming increasingly urbanized, more patients—when faced with the problems of describing their symptoms to a physician—are becoming able to express in words their experience of depression more accurately, as German (1972), for example, has shown in his studies.

An illustration of what is probably the combined effect of all these trends is provided by an inquiry among general practitioners in several European countries (Pöldinger, 1974). Between 73 and 90% of respondents in Austria, West Berlin, the Federal Republic of Germany, France, and Switzerland had the impression that the prevalence of depression in their everyday practice was increasing, and most of them reported that at least 10% of all the patients they saw in a year had depressive illnesses.

Although the size of the problem is now better recognized and effective treatment is available, most of the world's depressive patients remain untreated and thus exposed to unnecessary suffering and disablement; their families and communities also suffer major losses. This situation is particularly severe in the developing countries, although the number of untreated but treatable cases is far from trivial in the industrialized countries too. There are many reasons for this, ranging from poorly trained health workers and scarce resources, hindering the provision of effective medicaments; to insufficient knowledge about the nature, frequency, and management of depressive disorders.

The Mental Health Programme of the World Health Organization has as one of its main objectives the prevention and treatment of psychiatric and neurological disorders. To achieve it a two-pronged strategy has been adopted: firstly, major attention has been given to promoting the application in national health programmes of available knowledge through the development of decentralized mental health services integrated with general health services; and secondly, multidisciplinary research is being stimulated and coordinated, with the aim of bringing together scientists from different parts of the world and accelerating the process of acquisition of new knowledge.

The first step in effecting this strategy as it concerns depressive disorders was the development and promotion of a common language to facilitate communication among mental health workers in the field. Since the mid-1960s WHO has initiated several projects to develop internationally acceptable methods for the assessment, classification, and reporting of depressive disorders. The WHO programme on the standardization of psychiatric diagnosis and classification, in which groups of experts from many countries are collaborating, produced the proposals for the mental disorders section of the Ninth Revision of the International Classification of Diseases (WHO, 1978), which unlike earlier revisions contains a larger number of rubrics for the classification of depressive conditions and a companion glossary. In another

project concerned with the prevention of suicide, efforts were made to discover the reasons for unreliability in the reporting of suicide and attempted suicide (WHO, 1974).

In another major collaborative study (the International Pilot Study of Schizophrenia, WHO, 1973; 1979), over 1200 patients in nine countries were assessed with standardized methods and followed up over five years. Although its main focus was on schizophrenic disorders, a total of 256 patients with depressive conditions were included as a comparison group. The results indicated, firstly, that standardized techniques can be developed for assessing patients with severe mental disorders—including depression—in different cultures; and secondly, that psychiatrists educated in different traditions and schools can be trained to apply such techniques uniformly and reliably. The use of standardized techniques demonstrated that depressive patients identified in nine very different cultures had many characteristics in common, and formed a group that could be distinguished from the group of schizophrenic patients by symptomatology and prognosis.

The possibilities of improving the treatment of depression in the context of general health care are being explored in the framework of a broader investigation of the possibility of introducing mental health components into primary health care services (Harding, 1977). This study is being carried out in seven developing countries: Brazil, Colombia, Egypt, India, the Philippines, Senegal, and Sudan. A baseline investigation of morbidity and services in the catchment areas of the centres has been completed and is now being followed by designing methods of training for specific tasks to be carried out by general health service personnel. After a certain period, during which such tasks will be performed in the general health services, a second evaluation of the mental health situation in the area will be undertaken to assess the effect of the training and organizational intervention.

Simultaneously with these studies on diagnosis, assessment, and classification, WHO has initiated and is coordinating collaborative research on the biological aspects of depressive disorders. Research centres in developed and developing countries are cooperating in projects dealing with the biochemistry, psychopharmacology, and genetics of depression. Thus, for example, the effects of antidepressive drugs are being assessed in a series of patients in different sociocultural and climatic settings (Sartorius, 1973; Vartanian, 1976). This investigation stemmed from observations that there seemed to be differences in the responses to specific medicaments of groups of people from different ethnic groups, and differences in the doses needed to achieve a beneficial response between countries that differ in climate and in the nutritional status and other characteristics of patients. Also under WHO sponsorship, a number of centres are collaborating in studies on genetic aspects and biochemical mechanisms of depressive disorders (Coppen et al., 1977; Gershon et al., 1980) and adding to our store of knowledge by using the advanced laboratory and clinical facilities existing in leading research institutions in the world.

The study described in this report was conceived in 1970 with the collaboration of research centres in Canada (Douglas Hospital and the

Department of Psychiatry in the Montreal General Hospital), Iran (Department of Psychiatry, University of Teheran), Japan (Department of Neuropsychiatry, Nagasaki University School of Medicine, Nagasaki, and Department of Neurology and Psychiatry, Jikei University School of Medicine, Tokyo), and Switzerland (University Psychiatric Clinic, Basle). The first meeting of the collaborating investigators from all the centres took place in early 1972 and, following preparatory work, data collection began later in the same year.

As in other WHO-coordinated research, this study has to contribute to three goals: first, to strengthen the research capacity of centres collaborating in research on problems of public health importance; second, to develop further the methods and instruments needed to study such problems; and third, to make a contribution to knowledge.

More specifically, the project set out to achieve the following objectives:

(*a*) To develop and test simple instruments for clinical description of depressive states; the instruments should be easy to learn and apply, and at the same time sufficiently standardized to allow cross-cultural comparisons to be made;

(*b*) To examine with such instruments series of "average" depressive patients in different cultures, selected among those consulting psychiatrists; and

(*c*) To set up in this process a network of field research centres that would then be capable of initiating epidemiological and follow-up studies, therapeutic trials, and other investigations, as well as providing training to other investigators interested in adopting the same approach.

The report summarizes the experiences of the field investigators and WHO staff collaborating in the first phase of the study, during which methods and instruments were developed, training procedures implemented, and patients selected and assessed in the five research centres.

In the later phases of the project the investigators carried out a follow-up study in which the patients were re-evaluated five years after the initial assessment. In addition, the field research centres undertook studies aimed at determining the proportion of patients with depressive orders among all people attending general health services, and assessing their clinical and social characteristics. The results of these studies and the reviews[1] of the epidemiological literature and rating scales for depression will be published separately.

The instruments developed in the course of the WHO studies have already found wider applications, for example, in assessing the effects of treatment (Reisby et al., 1977; Takahashi et al., 1979), epidemiological surveys (Jablensky et al., 1981), and general practice research (Katschnig et al., 1980). Teams of investigators in other countries (Bulgaria, Federal Republic of Germany, Ghana, India, and Poland) have undertaken clinical, service-oriented, and epidemiological studies utilizing the methodological tools first tested in the five research centres listed above.

Depression is an area of research in which important results can be expected in the not very distant future, leading to improved methods for

[1] Prepared as background documents for the project by Dr F. Fenton (Montreal).

prevention and treatment. Different approaches—epidemiological, clinical, biological, and psychosocial—are likely to contribute jointly to this goal, but a prerequisite for their effective integration is the much needed "common language" in the description of depressive states and their classification (Kendell, 1976; Lehmann, 1977). The collaborative efforts of the investigators in the present study, sustained over a number of years, will be amply rewarded if the results of this investigation prove to be a step towards the establishment of an internationally used set of concepts for eliciting and describing clinical findings in depression.

1. Objectives, design, and instrumentation of the study

Objectives

The objectives of the initial assessment phase of the project, whose results are being presented in this report, were:

(*a*) To select suitable study areas and collaborating institutions in several countries that differ from each other with regard to culture, patterns of socioeconomic development, types and methods of operation of the health services, and psychiatric tradition;

(*b*) To develop standardized instruments and procedures for the selection and assessment of patients with depressive disorders from among all those seeking psychiatric care;

(*c*) To train psychiatrists at the collaborating centres to use the instruments developed for the study in a reliable and uniform manner;

(*d*) To assess, with the help of these instruments, series of patients suffering from depressive conditions and to compare their characteristics across the centres.

The achievement of these objectives was intended to establish a baseline for the subsequent part of the project, which was to investigate the course and outcome of depression in different cultures, assess its social consequences, describe the various approaches to its treatment and management, and extend case-finding for depressive conditions into general health services. The latter would not only provide information about the number and types of depressive conditions reaching general health services and about the treatment they receive but would also create a basis for research leading to their better management (Sartorius et al., 1980).

Study areas and facilities

The five selected study areas present interesting demographic, cultural, and social differences that are discussed in detail in Chapter 2. One of them is in a developing country (Iran) where the psychiatric facility chosen for the study has to deal with patients of extremely varied socioeconomic and educational background. The study area in Canada is characterized by its multi-ethnic composition and high social and geographic mobility. The area selected in Switzerland is an urban community with a high proportion of elderly people and relative economic and social stability. The two study areas in Japan contrast in some respects: one (Tokyo) is a vast urban agglomeration and the other (Nagasaki) includes a proportion of rural population and is more traditional in its organization and way of life.

The selection of study areas, however, was by no means intended to be representative of the variety of socioeconomic and cultural conditions in developing and developed countries: attempts to link the findings of the study to specific social, economic, or cultural variables should therefore be seen mainly as efforts to generate hypotheses for future work.

In selecting the study areas, previous findings, public health considerations, and certain hypotheses about depressive disorders (such as the often quoted absence of guilt in patients in Japan, the importance of depression in higher age, and the influence of religion) were taken into account as well as the presence in these areas of teams of investigators who had carried out important previous work on depression and were willing to collaborate in developing new methods of assessing depressive conditions that would allow international comparisons.

Each field research centre was located at a psychiatric treatment facility—a hospital or university clinic—that could be expected to admit a sufficiently large number of depressive patients to make the selection of a study population possible. For the purposes of the project, each centre was requested to delineate a catchment area. The size of the catchment area varied, but as a general rule it encompassed the city in which the centre was located and the surrounding countryside up to a radius of 80 km.

Selection of patients for the study

It was agreed to include in the study all patients residing or sleeping in the catchment area for at least six months prior to the beginning of data collection, provided that they met a number of criteria that strongly indicated that they were suffering from a depressive illness not attributable to cerebral damage, senile brain disease, or toxic disorder. The diagnostic classification of eligible patients (e.g., "endogenous", "reactive", "psychotic" or "nonpsychotic") was not taken into consideration at that stage of selection; a sufficient condition for inclusion was the presence of depressive symptoms in the absence of clear indications of other functional or organic psychiatric illness. Supplementary criteria were specified to exclude patients who would be difficult to assess by the ordinary methods of clinical investigation (history taking, mental state

examination) because of either severely subnormal intelligence or marked sensory defects.

Thus, the criteria for the selection of patients for the study in all the centres were as follows:

Criterion	*Rationale*
(1) *Age 10–70 years*	To include the entire lifetime risk period for depressive disorders.
(2) *Absence of definite physical disease, toxic disorder, or cerebral damage or disease*	To exclude depressive conditions of an organic origin where treatment and prognosis are determined primarily by the underlying disease.
(3) *Normal intelligence (IQ 70 or higher)*	To exclude patients with whom it would be difficult to carry out a full clinical interview, and patients whose mental subnormality rather than the depression would in the long run determine their management and the outcome.
(4) *Absence of severe language or hearing difficulties*	To exclude patients difficult to interview.
(5) *Absence of psychopathological symptoms indicative of schizophrenia or other non-affective functional psychosis*	To exclude schizophrenia, paranoid psychosis, and reactive psychoses other than depressive, even if accompanied by some depressive symptoms. For example, thought withdrawal, intrusion, and echo of thoughts; delusions or hallucinations not based on a depressed mood would exclude the patient from the study.
(6) *Presence of at least two of the following symptoms: depressive mood, feeling of worthlessness, hopelessness, hypochondriasis, anxiety, suicidal thoughts, feeling of diminution of abilities, self-reproach or guilt, inability to feel or enjoy.*	To include patients who were most likely to be suffering from depressive illness.

These criteria were applied in a screening procedure (see Screen Form, Annex 2), that assessed consecutive admissions or attendances at the facility and selected patients who satisfied the conditions for inclusion.