Consensus Statement on Transcultural Issues in Depression and Anxiety From the International Consensus Group on Depression and Anxiety

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Objective: To provide primary care physicians with a better understanding of transcultural issues in depression and anxiety. ***Participants:*** The 4 members of the International Consensus Group on Depression and Anxiety were James C. Ballenger (chair), Jonathan R. T. Davidson, Yves Lecrubier, and David J. Nutt. Five faculty invited by the chair also participated: Laurence J. Kirmayer, Jean-Pierre Lépine, Keh-Ming Lin, Osamu Tajima, and Yutaka Ono. ***Evidence:*** The consensus statement is based on the 5 review articles that are published in this supplement and the scientific literature relevant to the issues reviewed in these articles. ***Consensus process:*** Group meetings were held over a 2-day period. On day 1, the group discussed the review articles, and the chair identified key issues for further debate. On day 2, the group discussed these issues to arrive at a consensus view. After the group meetings, the consensus statement was drafted by the chair and approved by all attendees. ***Conclusion:*** The consensus statement underlines the prevalence of depression and anxiety disorders across all cultures and nations while recognizing that cultural differences exist in symptom presentation and prevalence estimates. In all countries, the recognition of depression by clinicians in the primary care setting is low (generally less than 50%), and the consensus group recommends a 2-step process to aid the recognition and diagnosis of depression. In line with the low recognition of depression and anxiety disorders is the finding that only a small proportion of patients with depression or anxiety are receiving appropriate treatments for their condition. Biological diversity across ethnic groups may account for the differential sensitivity of some groups to psychotropic medication, but this area requires further investigation.

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The cornerstone of research into transcultural variations in depression and anxiety disorders has been the prevalence estimates obtained from large epidemiologic surveys conducted across different countries. In formulating our views, we have considered the findings of such surveys and in addition have considered research findings on cultural and biological diversity. Our objective was to provide clinicians with a better understanding of cultural variation in the prevalence, presentation, diagnosis, and management of depression and anxiety disorders by identifying what is known in the field and what requires further research. This article represents our views and clinical recommendations based on our assessment of the available clinical evidence.

PREVALENCE OF DEPRESSION AND ANXIETY

That depressive disorders and anxiety disorders exist in all countries and cultures is a view supported by the findings of large epidemiologic surveys such as the Cross-National Study.[1] Although centers in different countries have consistently identified depression and all of the anxiety disorders, they appear to show cross-national variations in their prevalence. The degree of variability is greater for anxiety disorders than for depression and is most marked for generalized anxiety disorder (GAD), which occurs with prevalence rates that range from 0.9% to 37.0%.[2,3] However, most epidemiologic surveys were conducted at a time when the reliability of GAD assessment was low compared with the reliability of assessment

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of disorders such as major depression or panic disorder. Current, large-scale epidemiologic investigations of the prevalence of psychiatric disorders such as the European Study of Epidemiology of Mental Disorders (ESEMeD) and the World Health Organization (WHO) World Mental Health 2000 Study, which are utilizing similar methodological approaches, should facilitate future comparisons of the prevalence of depression and anxiety disorders around the world. However, these studies all employ standard criteria developed largely in Western settings and may not capture the full range of anxiety and depression-related problems in cultures in which modes of expression of distress differ from these implicit norms.

Research Need: Further study of GAD is needed, since the diagnostic criteria are now more stable and there is greater reliability in the assessment of the disorder. Research using modified criteria, incorporating culture-specific symptoms, and avoiding key items that may exclude patients with, for example, less prominent mood or anxiety symptoms is needed to establish more accurate prevalence estimates.

BURDEN OF DISEASE

The magnitude of the burden associated with psychiatric disorders has been illustrated by the WHO, which has indicated that, by 2020, major depression will be second only to ischemic heart disease as a cause of disability worldwide.[4,5] This burden is predicted to be even greater in the developing world, where major depression is set to become the leading cause of disability by 2020.[4,5]

There is good evidence that the burdens imposed by psychiatric disorders such as depression and anxiety are similar across different cultures.[2] At centers in the WHO project on Psychological Problems in General Health Care (WHO-PPGHC), there was consistency in the evaluation of the disease burden between patients and physicians as well as local conductors of the interviews, who were asked for their opinion on the burden to the patient. In addition, a consistent finding across centers was that stigmatization increased the burden imposed by psychiatric disorders on the patient.

Stigmatization

Depression is subject to far more stigmatization than somatic complaints, which may account for the ways in which patients present, even in psychiatric surveys, and may have a significant impact on the course of their illness. For example, depression may be associated with personal weakness in some cultural groups who may tend to deny or minimize the psychological aspects of their illness in favor of more socially acceptable somatic symptoms (see article by Kirmayer[6] in this supplement).

The level of stigmatization is reduced when a culture accepts depression, not as a self-diminishing illness but as a biological illness, with an imbalance that can be corrected by appropriate treatment. In Western cultures, where depression is being more effectively identified and treated, stigmatization appears to be decreasing. The increasing acceptance of psychological notions of the person also contributes to this decreased stigma. When patients present to their primary care physician, they will increasingly volunteer that they "feel depressed," which simply means that they have some psychological problem. Typically, they will refer to feeling either depressed, because they now appreciate that depression is a treatable condition, or stressed, because stress is an external cause that does not imply any personal fault. Another indicator of the decrease in stigmatization is the change in the male-to-female ratio of patients consulting psychiatrists. Furthermore, the proportion of men who consult psychiatrists for stress-related problems is increasing as they lose their fear of stigmatization. However, the majority of patients with major depression and panic disorder in primary care settings around the world continue to present with somatic symptoms.

In some cultures, such as Japan, it is far more socially acceptable for patients to talk about stress-related problems than depression. Studies have indicated that, in Japan in particular, stressful events and problems related to work, together with the process of industrialization as a whole, may play a role in the onset of depression.

Research Need: The WHO initiative has included a study on stigmatization and its effects on respondents in epidemiologic surveys and its influence on sufferers seeking medical help. Transcultural stigmatization is an important subject, and further studies are needed on the factors surrounding it and what can be done to improve case definition and the process of obtaining medical help and subsequent clinical management.

EPIDEMIOLOGIC SURVEYS: TRANSCULTURAL DIFFERENCES

Methodological Issues

Apparent differences in depression and anxiety prevalence and disability data from one country to another may be attributable to methodological issues, such as differences in population sampling, lack of uniformity in the method of clinical assessment, differences in classification, or problems related to the translation, and verification of translation, of instruments. There is also the issue of semantic agreement on concepts. However good a translation may be, the right questions may not be asked to explore possible symptoms. Lack of culturally appropriate language in the questions in the Composite International Diagnostic Interview (CIDI) may in part explain the nota-

bly low rates of social phobia detected in epidemiologic surveys in Japan. Furthermore, questions that are acceptable in one country may prove unacceptable in another. This was the case in the WHO-PPGHC study, where it was extremely difficult to ask about alcohol consumption at the center in Ankara, Turkey, because the question was considered offensive, particularly to women. How hierarchical rules are applied and interpreted will also lead to variation, for example, whether or not raters exclude subjects with comorbid major depression from a survey of GAD.

From our review of epidemiologic surveys, we have singled out the WHO-PPGHC, using the CIDI, as the best general epidemiologic survey of depression and anxiety in primary care worldwide. This survey has provided the best compromise between feasibility and methodological rigor, although it does have weaknesses, the major one being that the participating centers were not necessarily representative of the country where the assessment was made. In other words, the survey has provided information about the different centers but not whether there are real differences between countries. The study involves clinical epidemiology in Western-style health care settings that are not representative of the range of health care in many countries, and it cannot replace community epidemiology—especially given the fact that many patients with anxiety or affective disorders will not seek medical care but resort to other sources of help.

Our overall message to clinicians is that variations in epidemiologic data across cultures do not necessarily reflect reality but to an unknown extent may be consequences of methodological issues. Anomalous results that are inexplicable may mean that the methodology has to be refined. We refer the interested reader to specialist publications on methodology by Regier and colleagues[7] and cross-cultural assessments by Flaherty and colleagues[8] as well as to the article by Lépine[9] in this supplement. Where there are true differences in epidemiologic surveys, we need to consider whether these would generate a new hypothesis to shape our conceptualization of psychiatric disorders.

Research Needs:

1. We need to understand why response rates for epidemiologic studies are decreasing (to as low as 20% to 30% in some countries), because this decrease will confound any conclusions from future studies.
2. We need to use cross-cultural information as a research tool to validate our hypotheses. We may have to identify not only risk factors, but also protective factors.
3. There is a need for more data on the prevalence of depression and anxiety in the community in Japan and other countries. There is a need to explore alternate symptom sets and diagnostic criteria to avoid the "category fallacy" and capture the full range and best typification of disorders and distress in different countries.
4. In the near future, epidemiology will not only be descriptive and analytical, but will also include intervention research. It is important to evaluate the most relevant timing for intervention. Early intervention is not necessarily always the best option, as typified by debriefing after acute trauma, which has been applied to all subjects, rather than waiting to identify those who will benefit from intervention.[10]

CHARACTERISTICS AND COURSE OF DEPRESSION AND ANXIETY

In general, it appears that the presence of depression and anxiety disorders is consistently reported in epidemiologic surveys across national boundaries, even though there appear to be cross-national variations in prevalence rates.

Sociodemographic Factors

Overall, there are a number of relatively robust factors such as age at onset, sex ratio, and natural history that are similar for depression and anxiety across cultures. The observation that women are more likely than men to be depressed and anxious has been one of the most consistent and stable findings in epidemiologic surveys. In addition, the mean age at onset of major depression seems to be in the late 20s in population samples in most countries.[9] In contrast, in Japan there is a clinical impression that depression seems to be more common among men, since men seek treatment more frequently than women. However, there are no data currently available on the numbers of depressed women in Japan or the numbers who fail to seek help.

The transcultural variation in the pattern of suicide among males and females (see Suicidality below) has raised questions about the sensitivity of sex ratios to social and cultural factors. However, it should be remembered that suicide is an outcome and that depression is only one possible contributor to that outcome.

Symptom Patterns

For patients to fulfill the diagnostic criteria for major depression, they must have either depressed mood or loss of interest. However, these symptoms may not be prominent in many cultures, and, in any event, their mode of expression varies widely. Beyond mood symptoms, the most commonly reported symptoms of major depression in all countries in the Cross-National Study are insomnia, loss of energy, and suicidal thoughts.[1] This finding would suggest a different definition of the key or core symptoms of

depression. These symptoms were reported consistently in centers in different countries. However, it should be remembered that there are wide interindividual variations in the signs and symptoms of major depression within a specific population. These variations have important implications for the clinical interpretation of epidemiologic data because of the risk that clinicians will try to apply ethnic generalizations to individual patients rather than using the data to raise the series of questions they have to ask about the individual case.

Comorbidity

At least 50% of patients with a primary diagnosis of depression or an anxiety disorder have an associated psychiatric disorder. Comorbidity is associated with increased symptom severity, greater disability, and increased suicidality. The suicide rate increases significantly when depression and anxiety disorders coexist, a finding that has been shown to be consistent across cultures. For the primary care physician, in particular, the impact of comorbid somatic disease on depression and anxiety is an important consideration. Our generally held view of the nature of psychiatric disorders has been called into question by the high rates of comorbidity that occur, which have suggested that the existing categories are not pure and do not represent the natural cleavage lines of illness. For instance, when there is more distress, more categories are required to describe the severity of what someone is suffering. Thus, the possibility that many psychiatric phenomena are dimensional in nature rather than categorical is one that is attracting increasing attention.

Disease Course

When the lifetime course of comorbidity of psychiatric disorders is followed in patients over 10 or 20 years, it can be seen how patients switch from anxiety disorder to major depression. For example, in the U.S. population, data from the Epidemiologic Catchment Area study that have been broadly confirmed by the National Comorbidity Survey have shown that anxiety precedes depression in most cases.[11,12] Similar results were found for social phobia in the French sample of the WHO study.[13] In the International WHO/ADAMHA CIDI field trial, results have shown that for the majority of subjects with both anxiety and depression, depression clearly followed anxiety.[14] However, data are sometimes lacking in specific cultural settings.

Research Needs:

1. More data are needed on the longitudinal course of comorbidity in different cultures, the evolution of depressive and anxiety disorders, and how one disorder predicts another.
2. If anxiety disorders do precede depression, will modification or treatment of anxiety prevent the development of depression?

SUICIDALITY

Suicidality is a consistent finding in epidemiologic surveys of depression and anxiety in the community. The accepted view has been that suicidal ideation is higher among females than among males, whereas completed suicides are higher among males. However, we see this as a stereotype based on studies in societies and groups more similar than different in terms of global perspective. Suicidality is an evolving field in which recognition of cultural differences is changing the accepted pattern.

The trend toward a female preponderance in suicidal ideation has been observed in populations in North America and Europe, and also in Japan. However, it is among young males that suicidal ideation and suicide attempts are highest among Inuit populations in Canada[15] and among other indigenous peoples in Canada and Micronesia. Similarly, the rates of completed suicides are higher in males than females in the West and Japan, but the highest rate of completed suicides in the world has been found in young women in rural China.[16] Among the industrialized countries, Japan appears to have the highest proportion of completed suicides. The rate of completed suicides in Japan increased gradually from 1993 and has sharply increased since 1998.[17] Thus, it would appear that in many cultures, suicidality is powerfully shaped by social contingencies or rapid culture change.

We considered what measures or interventions could potentially lower the rate of suicide, while recognizing that suicide is not a single entity. For example, among patients with bipolar depression, prescription of lithium is effective in lowering the risk of suicide.[18] In addition, evidence from Sweden has indicated that the introduction of the selective serotonin reuptake inhibitors (SSRIs), and consequent increased use of antidepressants, has halted the increase in rates of suicide.[19] However, in situations where psychosocial factors create endemic problems, medication may be insufficient.

Psychosocial factors are also an important consideration in relation to suicidality. Having a family or children protects against the risk of suicide, while a good environment and a wider circle of contacts lowers the suicide rate among the elderly. Further interesting data on community support have come from Japan, where there is a high suicide rate in the elderly population.[20] It would appear that for elderly Japanese, living with their family offers no protective effect against suicide, whereas living alone and getting social interaction from community visits is protective and dependent on the number of visits.

Social integration has tended to be viewed as a positive factor, but this may not always be the case. For example, evidence from China has indicated that among young females in rural areas, intolerable social situations caused by oppressive family and marital relationships are a burden that contributes to suicidal ideation.[16] In general, although

suicide is an outcome to which depression and anxiety both contribute, they are not the only causes. While effective treatment of depression and anxiety is an important contributor to the prevention of suicidality, broader intervention is also required.

Research Need: Further study is needed on the association between suicidality and economic and social circumstances, alcohol use, divorce, rapid culture change, and the breakdown of extended family networks and community supports.

SUBTHRESHOLD DISORDERS

Subthreshold disorders are defined by the absence of one of the symptoms required to meet full diagnostic criteria or by failing to meet the criterion for duration. Although not meeting full diagnostic criteria, subthreshold disorders can still be a cause of substantial disability. In the WHO-PPGHC study, subthreshold mixed anxiety/depression was associated with 6.0 disability days in the previous month compared with 6.4 days for major depression. However, before advocating that physicians detect and go on to treat subthreshold disorders, we need evidence to support the value of such intervention. For example, the use of the ICD-10 PHC guidelines for detecting and managing depression in primary care has led to a significant increase in the numbers of patients diagnosed with depression or unexplained somatic symptoms[21] and has increased physicians' confidence in making such diagnoses.[22] There is a concern that lowering the threshold of detection in primary care will result in inappropriate diagnosis and treatment of subjects.[23] This represents an important transcultural issue, since a psychiatric diagnosis or label is a serious stigma in some cultures.

The recognition and treatment of subthreshold disorders in primary care has obvious consequences in terms of the development of health care policies. The most important point is not to confuse the threshold for diagnosis with the need for treatment. This represents a complex cross-cultural issue, since a patient may meet the full diagnostic criteria but not have any disability and not require treatment, or a patient may have a subthreshold disorder but suffer from a high level of disability with a need for treatment.[24] We believe that judging disability in a cultural context is a more sensitive and valid indicator of the need for treatment than diagnosis, and we recognize that many clinicians are driven by this view to a large degree. Thus, functional disability has to be assessed in a cultural context, since functionality varies with lifestyle and is largely dependent on the social expectations in a culture.

We have also recognized that subthreshold issues depend on the nature of the disorder. For example, there is a clinical perception that the diagnostic threshold is set too high in posttraumatic stress disorder (PTSD). Subjects with PTSD have to have many avoidant symptoms to meet the full diagnostic criteria, yet there are many subjects with significant disability who do not meet full diagnostic criteria.

The reality of subthreshold conditions is relative because these are not stable symptomatic conditions. Many of these conditions, however, do move to full diagnostic criteria within 1 year.[25]

Research Need: Further research is needed on appropriate cross-cultural measures of functional disability, particularly in relation to women, for whom functional dysfunction may not be best measured in terms of days of commercial work lost.

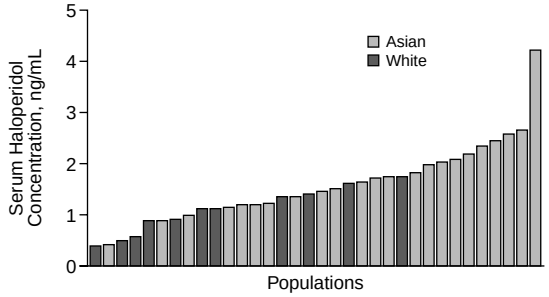
ETHNICITY AND BIOLOGICAL MARKERS

Studies of potential neurobiological correlates of depression and anxiety disorders have led to some interesting and tantalizing suggestions that there are differences across ethnic groups in relation to sleep architecture, particularly in males. In addition, as well as differences in rapid eye movement sleep patterns, differences in dexamethasone and cortisol levels have been observed in small samples. However, further studies are needed to confirm the findings of biological variability because of the relevance of the possible consequences of these differences.

Biological differences between ethnic groups may influence the pharmacokinetics and pharmacodynamics of psychotropic drugs and may be a consequence of pharmacogenetic differences, e.g., in drug-metabolizing enzymes, between different ethnic groups (see the article by Lin[26] in this supplement). The pharmacokinetics of psychotropic drugs can be affected by ethnic influences on both genetic and environmental factors. For example, white populations appear to have lower serum haloperidol concentrations than Asian populations[27] and lower blood concentrations of the tricyclic antidepressant nortriptyline than Japanese individuals.[28] However, cross-ethnic differences are often embedded or superimposed on interindividual variations. Thus, within-group variation in pharmacokinetics can be as large as cross-cultural differences (Figure 1). In considering the needs of the individual patient, the clinician must consider the overlap of the two and not discount ethnic differences.

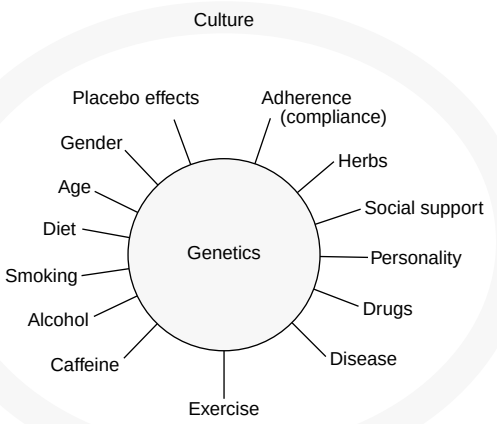
In terms of pharmacodynamics, there may be differences across ethnic groups in the drug concentration needed to produce a pharmacologic effect. For example, Asian patients with schizophrenia are observed to have greater prolactin responses than white patients with similar blood levels of haloperidol.[19] There is every reason to believe that significant pharmacodynamic effects can result from ethnic differences, but this is a difficult area of research that has received little attention.

Figure 1. Maximal Haloperidol Concentration in Different Populations[a]



[a]Reprinted, with permission, from Lin and Smith.[34]

Figure 2. Factors Affecting Drug Response[a]



[a]Adapted, with permission, from Lin and Smith.[34]

With regard to pharmacogenetics, ethnicity may affect the different forms of drug-metabolizing enzymes. The potential consequences of such ethnic differences are that different doses of a drug may need to be given in different ethnic groups and that there may well be a risk of more significant drug-drug interactions in different groups. Factors affecting drug response are summarized in Figure 2.

Implications for Clinicians

For reasons of complexity and cost, it will prove impossible to conduct clinical research on every possible ethnic group and subgroup. This is why there are rules of thumb for clinicians, for example, to guide them on the appropriate approach when a patient fails to respond to treatment or on the appropriate strategy for underdosing or overdosing. However, it is important for clinicians to realize that these are general rules since, for example, while it is true that Asians generally need a lower dose of medication, it is not the case for every individual, and some may require higher doses. Thus, the maxim should always be to consider the individual patient. Ethnocultural differences can be a source of increased variability, not of stereotypy and sameness.

Implications for Clinical Research

There is a case to be made for including ethnicity in the early-stage evaluation of new psychotropic drugs to assess how it influences their pharmacokinetics and whether it affects how they are metabolized. Not only are there ethnic differences in terms of genetics, but also in terms of diet and other cultural factors; in particular, the influence of diet on pharmacokinetics may be another important consideration in this context. We recommend further documentation of adverse events and drug interactions by ethnic group in clinical research to gain greater understanding of ethnicity and pharmacogenetics. Unless representative populations are included in clinical trials, the gaps in our knowledge in this area will be perpetuated. In the United States, for example, there is now a degree of inconsistency between government-funded and other sponsored research, since the National Institute of Mental Health has imposed a requirement for ethnic representation in clinical trials.

Implications for Policy Makers

The question of the distinction between efficacy research versus effectiveness research has been attracting increasing attention. In efficacy research, patients are selected to provide a more homogeneous population with the aim of maximizing the chances of finding a significant difference from placebo, while avoiding confounding factors (e.g., no hypnotic agent allowed for anxious patients even in the case of insomnia). When the drug or treatment approach is proven efficacious and approved for clinical use, it is utilized with many patients who were excluded from the research program, whether for comorbidity, medical problems, or other reasons.

Thus, efficacy studies help us to understand the mechanisms involved, but they do not tell us whether our research findings apply to the majority of patients in clinical practice. Consequently, we need studies of effectiveness that include ethnicity and cultural factors among the other variables such as age or sex that are used to assess clinical effectiveness in later-stage studies.

Implications for Society

The debate about whether there are associations between biological markers and ethnic groups needs to be conducted responsibly in society if we are to avoid problems such as racial stereotyping. It must be stressed that multiple genes, whether 10, 20, or even 100, work together to determine responses to environmental cues. Therefore, it is not possible to identify single genes that determine behavior.

As more biological markers of depression and anxiety disorders are developed, they should be studied across different ethnic groups to determine whether there are significant differences, for example, in metabolism that may explain why a drug is effective in one group but not in another.

Research Need: All aspects of ethnicity and potential biological markers of depression and anxiety disorders will require systematic exploration, since fundamental information is still lacking. Further research is also needed on how diet and herbal medicines, which are used widely in many cultures, influence the pharmacokinetics of commonly used medications.

RECOGNITION OF PSYCHOLOGICAL CASES IN PRIMARY CARE

In all countries, although the prevalence of mental disorders in the community is high, many of the patients identified as presenting with psychological cases by research criteria are not identified in primary care settings.[21] Across nations, clinicians in primary care recognize only up to 50% of cases of depression.[3,29]

Recognition of psychiatric disorders by primary care physicians increases with symptom severity, diagnostic status, spontaneous reports of psychological complaints, and patient awareness and decreases when there is a somatic diagnosis (independent of the number of somatic symptoms) or when the patient belongs to a younger age group.[30] A study of physician characteristics associated with the recognition of depression and anxiety in primary care has indicated that doctors with negative attitudes toward depression or psychiatric disorders made fewer psychosocial assessments and were less accurate in detecting psychiatric distress.[31] This finding is consistent with the variation between centers in how well conditions are recognized, since some doctors are more reluctant than others to make a psychiatric diagnosis.

We advocate a stepwise approach to the recognition and diagnosis of psychiatric disorders analogous to those in other domains of medicine since there is no reason why primary care physicians should be expected to make a psychiatric diagnosis in a single consultation. Instruments should be adapted to provide physicians with a simple first step of case identification followed by a second step in which further details are taken to confirm what was found and form a diagnosis. The Mini-International Neuropsychiatric Interview has been adapted for use in this way and has led to improvement of the ability of the primary care physician to diagnose psychiatric disorders. When a patient first presents, the physician checks for a single criterion, for example, whether the patient is feeling blue or sad, then checks for loss of interest and chronic worries. This process takes around 3 minutes, and at the next visit, the physician explores the possibility of GAD if the patient had chronic worries, or depression if there was loss of interest. Thus, by working in this way, primary care physicians can improve their performance from making a specific diagnosis in 10% to 20% of cases to around 60%.[32]

We believe that such a stepwise approach would be applicable across cultures, with the proviso that the initial focus in some cultures might have to be more on somatic than emotional symptoms or personal questions, because this would be more appropriate and acceptable to patients. Clinicians will have to realize that talking about symptoms is not independent of the perception that people in a culture have about disease and that they will have to adopt a local approach to access, for example, depression.

In Western cultures, clinicians have been increasingly using a model for depression that has moved it out of the purely psychological domain. This has included telling patients that depression is a physical illness involving energy depletion and that psychological symptoms are just some of the symptoms it produces, and many people have found this model acceptable. It would be interesting to see how well this type of negotiation would work in other cultures. In countries like Japan, where acceptance of the concept of neurasthenia has persisted, it may be possible to have a clinical negotiation with patients without raising the issue of depression as such and still treat the syndrome correctly. Similarly, clinicians in the West do not always say that they think patients are suffering from depression. They refer instead to a chemical problem with the brain that produces symptoms and that can be treated with a transmitter-related drug. In addition, clinicians could also equally well refer to treatment with antineurasthenic drugs.

In a country such as Japan, clinicians who suspect depression could talk to their patients about low energy, or *gehn-ki*, as a way of negotiating or exploring their symptoms. Suicidality could be linked to the lack of energy or life force, and in traditional Chinese or Japanese medicine it would mean that the patient did not have enough circulation of energy, or *ki*, a view that could be roughly likened to the neurotransmitter concept of depression and anxiety disorders.

In general, it makes sense for clinicians to talk to patients in language they can understand, using common names and avoiding the use of stigmatizing terms. However, the disadvantage of not introducing new concepts to the patient is that clinicians are unable to explore symptoms that the patient is either reluctant to discuss or has not considered. Thus, clinicians have an educational role to fulfill, for example, explaining what depression is and getting patients to recognize their symptoms as part of depressive illness.

It is our recommendation that the first step in improving the recognition of psychiatric disorders is a campaign to educate the public and that the second is a campaign to

educate the physician. Across the world, primary care physicians have learned to rule out somatic disease before considering psychiatric disease. However, if the patient does not present with psychological complaints, this approach will be unsuccessful. The important educational message is that physicians should consider both at the same time.

PRESCRIPTION OF THERAPY

In keeping with the generally low rate of recognition of psychiatric disorders in primary care, only a small proportion of patients with a specific disorder are actually prescribed appropriate treatment. We estimate that these constitute about 10% of primary care patients in centers around the world.[33] The prescription of antidepressants or anxiolytics is less likely in the presence of a somatic diagnosis. Prescription of antidepressants is more likely if patients present with psychological complaints, are aged over 24 years, or have a comorbid disorder and thus an increased severity of symptoms. Similarly, anxiolytic prescription is linked to age, severity, and psychological complaints. There is also a correlation between antidepressant prescription and a diagnosis of depression by the primary care physician such that the prescription of treatment is accurate when there is a specific diagnosis. Therefore, improvement of the recognition and diagnosis of depression in primary care will lead to an improvement in treatment, with a consequent increase in the prescription of specific antidepressant therapy.

CLINICAL IMPLICATIONS OF CULTURAL DIFFERENCES

Cultural differences have a significant impact on the recognition and diagnosis of psychiatric disorders. For instance, when patients are interviewed, we have to accept that there are differences in patients' expectations and how they relate to clinicians. In the West, psychiatry is focused on the individual, whereas in many other parts of the world, people see their problems in the context of their families. They present with family members and want them to be involved in any explanation of what is happening. This contrasts starkly with Western psychiatry where, increasingly, families are excluded from consultations on ethical grounds.

The same range of symptoms of depression and anxiety can be identified in all cultures, but the question is whether the way the disorders are conceptualized in the Western tradition is necessarily the best way to categorize patients in other cultural settings. It may be preferable to accept existing conceptualizations and terminology rather than impose a Western model. In addition, when we consider the interpretation of symptoms, we acknowledge the influence of stereotypes. For example, the typical depressed patient in the United States is said to be a middle-aged woman who has multiple losses or an unsatisfactory marriage, whereas in Japan, it is a man in his 30s who has just gotten a promotion and is working too hard.

In all countries and cultures, public education campaigns are needed to reduce stigmatization. Although such initiatives are directed toward increasing appropriate help seeking and appropriate prescription of medication, they have wider implications for problem definition. In many cultures, there is no information about how much unmet need there is in the population and how much hidden morbidity exists, particularly among women, who are typically not as mobile as men or have a less prominent role in society. The effectiveness of educational initiatives will be influenced by the nature of the health care system. For example, in Japan, where occupational health is regarded as a priority, the emphasis on mental health in the work place is unique. This approach typically involves 2 types of intervention, from psychiatrists working in the company and Western-style psychiatrists outside the company. In Japan, it is easier to work within the company to help employees, but clinical experience suggests that mental health problems are increasing rapidly in such companies.

Individual differences are as great as ethnic differences, which is why clinicians should always focus on the individual. This may be a difficult message for overworked clinicians looking for a cultural rule of thumb to apply automatically in every case. Consultation times are universally short in primary care, but doctors should not feel constrained to make a psychiatric diagnosis in a single visit. The structured approach we advocate is preferable (see above). It takes time to provide basic quality care, and getting more time is central to the current debate between clinicians and managed care organizations in the United States.

The most important starting point for management is to treat the individual and not the ethnic group. The therapeutic options include pharmacotherapy, psychotherapy, and culturally specific treatments such as Morita therapy or herbal medicines. Clinical evidence supports the use of SSRIs as first-line therapy for depression and anxiety disorders. In addition, cognitive-behavioral therapy has been used to good effect in Western cultures where specialist psychological support is in place to provide such treatment.

In many cultures, alternative therapies and herbal remedies are in widespread popular use. Consequently, clinicians prescribing therapy must be aware that patients may well be taking combination therapy even if they have not prescribed it. Treatment must also be continued at an adequate dosage for an appropriate duration if it is to be effective. Furthermore, compliance with medication is a worldwide issue, and factors encouraging patients to continue taking medication as prescribed include good tolerability and once-daily dosage.

Drug names: haloperidol (Haldol and others), nortriptyline (Pamelor and others).

REFERENCES

1. Weissman MM, Bland RC, Canino GJ, et al. Cross-national epidemiology of major depression and bipolar disorder. JAMA 1996;276:293–299
2. Ustun TB, Sartorius N, eds. Mental Illness in General Health Care: An International Study. Chichester, England: Wiley Press; 1995
3. Goldberg DP, Lecrubier Y. Form and frequency of mental disorders across centres. In: Ustun TB, Sartorius N, eds. Mental Illness in General Health Care: An International Study. Chichester, England: Wiley Press; 1995: 323–334
4. Murray CJ, Lopez AD. Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study. Lancet 1997;349:1436–1442
5. Murray CJ, Lopez AD. Alternative projections of mortality and disability by cause 1990–2020: Global Burden of Disease Study. Lancet 1997;349: 1498–1504
6. Kirmayer LJ. Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. J Clin Psychiatry 2001;62(suppl 13):22–28
7. Regier DA, Kaelber CT, Rae DS, et al. Limitation of diagnostic criteria and assessment instruments for mental disorders: implications for research and policy. Arch Gen Psychiatry 1998;55:109–115
8. Flaherty JA, Gaviria FM, Pathak D, et al. Developing instruments for cross-cultural psychiatric research. J Nerv Ment Dis 1988;176:257–263
9. Lépine J-P. Epidemiology, burden, and disability in depression and anxiety. J Clin Psychiatry 2001;62(suppl 13):4–10
10. Solomon SD. Interventions for acute trauma response. Curr Opin Psychiatry 1999;12:175–180
11. Kessler RC, McGonagle KA, Zhao S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. Arch Gen Psychiatry 1994;51:8–19
12. Kessler RC, Nelson CB, McGonagle KA, et al. Comorbity of DSM-III-R major depressive disorder in the general population: results from the US National Comorbidity Survey. Br J Psychiatry Suppl 1996;30:17–30
13. Weiller E, Bisserbe JC, Boyer P, et al. Social phobia in general health care: an unrecognised, undertreated disabling disorder. Br J Psychiatry 1996; 168:169–174
14. Lépine JP, Wittchen HU, Essau CA, and participants of the WHO/ADAMHA CIDI Field Trials. Lifetime and current comorbidity of anxiety and affective disorders: results from the International WHO/ADAMHA CIDI field trial. Int J Meth Psychiatry Res 1993;3:67–77
15. Kirmayer LJ, Malus M, Boothroyd LJ. Suicide attempts among Inuit youth: a community survey of prevalence and risk factors. Acta Psychiatr Scand 1996;94:8–17
16. Ji J, Kleinman A, Becker AE. Suicide in contemporary China: a review of China's distinctive suicide demographics in their sociocultural context. Harv Rev Psychiatry 2001;9:1–12
17. Health and Welfare Statistics Association. J Health Welfare Statistics 2000;47
18. Müller-Oerlinghausen B, Grof P, Schou M, et al. Reduced mortality of manic-depressive patients in long-term lithium treatment. Psychiatry Res 1991;36:329–380
19. Isacsson G. Suicide prevention: a medical breakthrough? Acta Psychiatr Scand 2000;102:113–117
20. Oyama H, Koizumi T. Depression and suicide in the elderly. Shinryonaika 2000;4:256–264
21. Upton MW, Evans M, Goldberg DP, et al. Evaluation of ICD-10 PHC mental health guidelines in detecting and managing depression within primary care. Br J Psychiatry 1999;175:476–482
22. Goldberg D, Sharp D, Nanayakkara K. The field trial of the mental disorders section of ICD-10 designed for primary care (ICD10-PHC) in England. Fam Pract 1995;12:466–473
23. Schwenk TL, Klinkman MS, Coyne JC. Depression in the family physician's office: what the psychiatrist needs to know: the Michigan Depression Project. J Clin Psychiatry 1998;59(suppl 20):94–100
24. Spitzer RL, Kroenke K, Linzer M, et al. Health-related quality of life in primary care patients with mental disorders: results from the PRIME-MD 1000 Study. JAMA 1995;274:1511–1517
25. Judd LL, Akiskal HS, Zeller PJ, et al. Psychosocial disability during the long-term course of unipolar major depressive disorder. Arch Gen Psychiatry 2000;57:375–380
26. Lin K-M. Biological differences in depression and anxiety across races and ethnic groups. J Clin Psychiatry 2001;62(suppl 13):13–19
27. Lin K-M, Poland RE, Lau JK, et al. Haloperidol and prolactin concentrations in Asians and Caucasians. J Clin Psychopharmacol 1988;8: 195–201
28. Kishimoto A, Hollister LE. Nortriptyline kinetics in Japanese and Americans. J Clin Psychopharmacol 1984;4:171–172
29. Freeling P, Rao BM, Paykel ES, et al. Unrecognised depression in general practice. BMJ 1985;290:1880–1883
30. Lecrubier Y. Is depression under-recognised and undertreated? Int Clin Psychopharmacol 1998;13(suppl 5):3–6
31. Robbins JM, Kirmayer LJ, Cathebras P, et al. Physician characteristics and the recognition of depression and anxiety in primary care. Med Care 1994;32:795–812
32. Lecrubier Y, Bobes J, Gutierez M, et al. Validation of the MINI in four European countries. Eur Psychiatry. In press
33. Lecrubier Y, Weiller E. Characteristics, recognition and treatment of dysthymics in primary care. Eur Psychiatry 1998;13:198–202
34. Lin KM, Smith MW. Psychopharmacology in the context of culture and ethnicity. In: Ruiz P, ed. Ethnicity and Psychopharmacology. Washington, DC: American Psychiatric Association; 2000:1–36. Review of Psychiatry; vol 19, no. 4