CROSS-CULTURAL STUDIES OF DEPRESSION: A PRELIMINARY REPORT OF A SERIES OF STUDIES COORDINATED BY THE WORLD HEALTH ORGANIZATION

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Most authorities agree that depressive illnesses are a major public health problem world-wide.

In this paper, we report on the progress of a series of studies on depression, initiated and coordinated by the World Health Organization since 1972 in 5 Centers - Basel, Switzerland, Nagasaki and Tokyo, Japan, Teheran, Iran and Montreal, which has been chosen as the North American Center for these studies. The long-range goal of this work is to provide the knowledge to render prevention and treatment of depressive disorders more effective.

Our first step has been to develop ways of systematically detecting non-organic depressive disorders. For this purpose, we have tried to develop tools to assure clinicians and researchers working in different cultures that they are talking the same clinical language.

To be useful for clinical and research purposes, and at the same time be applicable cross-culturally, the ideal instrument should have several qualities:

- it should be valid, that is, it should measure what it is supposed to measure.
- it should be reliable, that is, it should yeild the same information when administered on different occasions or by different examiners.
- it should be as simple as possible, and acceptable to most respondents, and
- it should be economical to administer and to process.

I will briefly review 3 instruments we are developing with colleagues in the 4 other Centers.

First Slide Please

Two check-lists used so far in psychiatric treatment settings - the SCREEN FORM and the SCHEDULE FOR A STANDARDIZED ASSESSMENT OF PATIENTS WITH DEPRESSIVE DISORDERS, so-called the SADD, S-A-D-D, and a structured interview, the FOLLOW-UP ASSESSMENT SCHEDULE used to investigate the long-term outcome of patients treated for non-organic depressive disorders.

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We are testing a 4th instrument, not listed on the slide, designed for use by primary care, non-specialist practitioners to find out how many patients now receiving any kind of primary care are also sufficiently depressed to require treatment.

Looking at each of the three instruments in turn:

The SCREEN FORM has been developed to distinguish between non-organically depressed individuals and non-depressed individuals in clinical psychiatric settings.

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The FORM includes:

- patient's identification and demographic information
- 4 exclusion categories including definite physical disease, mental retardation, any of Schneider's first-rank symptoms, of schizophrenia and the presence of severe language or hearing difficulties.
- and 8 inclusion criteria listed on the next slide

Depressive mood

Suicidal thoughts

Hopelessness

Feeling of worthlessness

Hypochondriasis and/or anxiety

Feeling of diminution of ability

Self-reproach or guilt

Inability to feel or enjoy

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A glossary is available containing definitions of each exclusion and inclusion criterion, and also sample questions asked in each of the 5 Centers.

A respondent is considered depressed if none of the 4 exclusion criteria are present, and if at least 2 of the 8 inclusion criteria are present at interview. The SCREEN FORM can also be completed from information in case notes.

How close does this FORM come to being an ideal instrument for its purpose?

Reasonably close overall!

One possible drawback is that the FORM must be supplemented by a clinical interview - structured or otherwise - in order to confirm the diagnosis of non-organic depression of a specific type.

On the other hand:

- the FORM is efficient: it picks up a high percentage of patients independently assessed as being non-organically depressed (sensitivity), and rejects appropriately a high percentage of cases independently diagnosed as not depressed (specificity).

- Its reliability is acceptably high in each Center.
- It is simple to administer: can be done by a psychiatrist or trained mental health professional in 2 to 4 minutes.
- It is acceptable to almost all patients approached - over 1,200 in the 5 Centers.
- It is reasonably cheap: the direct costs of administering the FORM are low, and
- It has been translated into 5 languages: English, French, German, Japanese and Persian

The second instrument I mentioned is the SADD designed to find out if a reliable technique can be developed for recording and classifying symptoms of non-organic depressions in different parts of the world.

The SADD has been administered to 545 patients in the 5 Centers - the results will be published very shortly.

The SADD's contents include:

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- Patient's identification and demographic information
- 39 symptoms and signs relating to the patient's current clinical state. Ratings are assigned according to 2 criteria: the time when the symptom or sign was present, either during the previous month or any other time during the episode, and according to the intensity of the symptoms and signs.
- 18 items concerning past psychiatric history
- Information concerning current psychiatric treatment
- Patient's psychiatric diagnosis.

As with the SCREEN FORM, the SADD is accompanied by a glossary containing guidelines for ratings, definitions of the items, and questions asked concerning each item.

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How well does the SADD fill the bill as an ideal instrument for its purpose?

- It appears to be valid, that is it measures what it is supposed to measure. (Concurrent validity can be demonstrated, i.e. the SADD concurs with an experienced clinicians' diagnosis made independently).
- Its reliability is acceptably high.
- It is reasonably simple to administer, requiring 30 to 60 minutes to complete.
- It is acceptable to most respondents
- Direct costs are relatively high, however, The SADD is not commercially available yet, and no summary scoring system has been devised. The indirect costs are also relatively high because only experienced clinical personnel, with 10 to 12 hours training with the SADD, should be using it.
- It too has been translated into 5 languages: again, English, French, German, Japanese and Persian.

Overall, the SADD's most promising use right now is as a research tool. The time required to administer it, and its cost are potential disadvantages from the clinician's viewpoint.

The 3rd instrument we are working with is the FOLLOW-UP ASSESSMENT SCHEDULE - another starchy label, so starchy in fact that we are still trying in vain to coin a pleasant-sounding acronym.

We have used this instrument in a 5-year follow-uo of 545 patients, including 110 in Montreal, who responded to the SADD - and were diagnosed depressed - in 1972 and 1973.

This is an important study because it is one of the very few follow-up studies of depressive disorders in different cultures, and because information regarding clinical adjustment as well as social functioning is obtained with the same instrument.

The SCHEDULE's contents include:

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- Patient identification information
- How patient traced
- Current clinical symptoms and diagnosis. (A condensed version of Part II of the 5th edition of the SADD is used).
- Clinical state during the 5-year period, including psychiatric diagnoses made.
- Psychiatric treatment, present and past, and
- Social adjustment.

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So far this instrument appears to be useful:

- Its reliability is acceptably high. (In Montreal. No inter-Center reliability studies done yet).
- It is reasonably simple to administer. A psychiatrist or mental health professional can complete an interview in 45 to 90 minutes.
- It is acceptable to most respondents.
- The direct costs of processing the information are economical. However, indirect costs are fairly high, at the beginning especially, because experienced personnel is required with 18 to 20 hours of special training in the use of this instrument.
- As with the SCREEN FORM and the SADD, the FOLLOW-UP ASSESSMENT SCHEDULE has been translated into the 5 languages.

In conclusion, where do we stand now?

- Colleagues in 5 Centers in different parts of the world have developed 3 instruments to systematically detect and record non-organic depressive disorders in psychiatrically treated population. These instruments are applicable cross-culturally. The other instrument I mentioned in passing, designed to detect non-organic depressive disorders in non-psychiatric populations, is being tested.
- A network of collaborating centers have been established to use these instruments and to train others in their use.
- The SCREEN FORM and the SADD have been adopted for use in new centers engaged in clinical, epidemiological and biological studies of depression.

Finally, if any of you are interested in learning more about these instruments and their potential uses, please feel free to contact me or Dr. Fenton in Montreal.

REFERENCES

1. Sartorius, N. et al. International agreement on the assessment of depression. Preliminary communication on the WHO Collaborative Study on Standardized Assessment of Depressive Disorders. Paper prepared for the VI World Congress of Psychiatry, Honolulu, Hawaii, 28 August - 3 September, 1977.

2. Report of the Study of Standardized Assessment of Depressive Disorders, Second Draft. Mimeographed.

APPENDIX 1

GENERAL PRACTICE RATING SHEET

The 4th instrument, the so-called General Practice Rating Sheet (GPRS) is being developed for use by primary care, non-specialist practitioners, and tested in the 5 Centers to find out how many patients now receiving care from their family physician are also sufficiently depressed to require treatment. The results will help to answer three other important questions:

1. In how many patients who are depressed is the diagnosis missed?

2. What treatment is prescribed by the family doctor for depressed patients?

3. What educational measures could be devised and implemented to help physicians who are not psychiatrists diagnose and treat the depressed patients they see more effectively?

The Rating Sheet itself is completed by the primary care practitioner (family physician or nurse practitioner, for example) within 2-4 minutes after he or she has interviewed or examined a patient. Virtually no training is required to use this instrument. Ratings are based on the practitioner's judgement.

The General Practice Rating Sheet provides information concerning:

- Patient's identification (which can also be obtained by a secretary or clerk).

- The practitioner's impression whether the patient has a physical problem, a psychiatric problem. or both.

- The practitioner's impression of the nature of the psychiatric problem (if present).

- Whether any treatment, including referral to a specialist, is considered necessary.

This instrument is being tested in each of the 5 Centers. In Montreal to date, the Rating Sheet has been used by one English-speaking family practitioner in a solo practice, and by several French-speaking physicians working together in a local Community Health Center (CLSC).

The practitioner working solo has provided some results so far:

1. He consideres that 4.5% of the patients he sees to have psychiatric symptoms. In other words, about 1 in 20 patients consulting him was sufficiently depressed or anxious, or both to require treatment

2. Over one half of these depressed or anxious patients presented with physical symptoms.

3. His diagnosis of depression was accurate 9 times out of 10. (The SADD, administered independently, was used to validate the practitioner's diagnosis).

4. He treats virtually all the depressed and anxious patients he sees himself.

Summary - General Practice Rating Sheet

So far, we know that this instrument is easy to use, economical and acceptable to most patients (Not administered to children. Also, even though the instrument is quite short, it is cumbersome to carry about administering to patients during housecalls and visits to hospital).

It is too early to tell how efficient this Rating Sheet is in detecting depressed and anxious patients, and how it compares in this respect with other instruments available, Goldberg's General Health Questionnaire for example.

APPENDIX 2

SENSITIVITY AND SPECIFICITY OF THE SCREEN FORM

Sensitivity refers to the percentage of patients with non-organic depressive disorders - the diagnosis is made by qualified independent assessment - "picked up" as depressed by the SCREEN FORM. The FORM was administered to over 1,200 patients in the 5 Centers. Sensitivity ranged from 79% in Nagasaki to 97% in Tokyo. The sensitivity in Montreal is 82%. This means that the SCREEN FORM correctly "picked up" or "identified" depression correctly in 157 of the 192 cases independently diagnosed as non-organic depression.

Specificity refers to the percentage of patients who do not have non-organic depressive disorders - the diagnosis again made by qualified independent assessment - who are "rejected" as not depressed by the SCREEN FORM. The specificity of the FORM in the 5 Centers is also high, ranging from 79% in Tokyo, to 94% in Teheran. Again, Montreal sits roughly in the middle - the SCREEN FORM correctly identified patients as not depressed in 85% of the cases independently diagnosed as non-depressed.