WONCA Special Interest Group In Psychiatry and Neurology

Culturally Sensitive Depression Guideline

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Patient population:

Adults with depressive disorder in primary care

Key Points

- Depression is a common primary care psychiatric disorder with increasing incidence and prevalence.
- Globalisation means that primary care physicians across the world are increasingly treating patients with different ethnic backgrounds from their own.
- Primary care patients suffering from depression do not always present with the classical symptoms as described in ICD10 and DSM IV and often present with multiple somatic complaints.
- A patient's cultural background will influence the metaphor they choose to describe psychological distress and their mood state. The side effects and dosage of antidepressant agents may also depend upon ethnicity.
- LOOK, LISTEN, TEST is a form of assessment that is suitable for use in primary care consultations as it allows a holistic approach to care.

1. INTRODUCTION

Depression is a common psychiatric disorder in primary care throughout the world and is often under-treated and under-diagnosed (Ballenger et al 2001, Lecrubier 2001). Epidemiological studies show that the lifetime risk of experiencing depression varies with culture and gender. Females are more likely to suffer from depression, with a lifetime risk of 20–25% as compared to males whose lifetime risk is 7–12 %. The prevalence of deliberate self-harm in depression may be between 10% and 16% (Angst 1996) and mortality may be as high as 15% in hospitalised patients with depression (Murphy et al 1987).

The WHO predicted that by the year 2020 depression would be the second most important cause of disability after ischaemic heart disease worldwide (Murray & Lopez 1997). As many patients with depressive disorder initially present to the primary care physician, primary care workers need to be better equipped to deal with the diagnosis and manifestations of this disorder.

Carothers (1953) believed that depression was confined to the developed world and this view initially influenced early physicians. It is now believed that dysphoric mood is a universal phenomenon and that clinical features are dependant upon culture and language. There is transcultural variation in both the prevalence and presentation of depression. For example, in 1995 Goldberg & Lecrubier report a prevalence of 2.6% in Japan to 29.5% in Chile. Weissman et al (1996) have shown that the prevalence of depression varies from 1.5% in Taiwan to 19% in Lebanon.

Two major diagnostic criteria are used in the classification of depressive disorder, DSM IV (APA 1994) and ICD 10 (WHO 1992).

Table 1

DSM IV Criteria - Major Depressive Disorder

(American Psychiatric Association, 1994)

A. At least five of the following symptoms have been present during the same 2-week period, nearly every day, and represent a change from previous functioning. At least one of the symptoms must be either (1) depressed mood or (2) loss of interest or pleasure:
   - Depressed mood
   - Markedly diminished interest or pleasure in all, or almost all, activities
   - Significant weight loss or weight gain when not dieting
   - Insomnia or hypersomnia
   - Psychomotor agitation or retardation
   - Fatigue or loss of energy
   - Feelings of worthlessness or excessive or inappropriate guilt
   - Diminished ability to concentrate, or indecisiveness

   Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, a suicide attempt or a specific plan for committing suicide.

B. Symptoms are not better accounted for by a Mood Disorder due to a General Medical Condition, a Substance-Induced Mood Disorder, or Bereavement.

C. Symptoms are not better accounted for by a Psychotic Disorder (e.g. Schizoaffective Disorder).

D. Symptoms do not meet criteria for a mixed bipolar episode, where criteria are met both for a manic episode and a major depressive episode.

Table 2

ICD 10 Criteria - Depressive Episode

(WHO 1992)

In typical depressive episodes of all three varieties described below mild, moderate, and severe, the individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatigability and diminished activity. Marked tiredness after only slight effort is common.

Other common symptoms are:
- reduced concentration and attention;
- reduced self-esteem and self-confidence;
- ideas of guilt and unworthiness (even in a mild type of episode);
- bleak and pessimistic views of the future;
- ideas or acts of self-harm or suicide;
- disturbed sleep;
- diminished appetite

Mild Depressive Episode

Depressed mood, loss of interest and enjoyment, and increased fatigability are usually regarded as the most typical symptoms of depression, and at least two of these, plus at least two of the other symptoms described above should usually be present for a definite diagnosis. None of the symptoms should be present to an intense degree. Minimum duration of the whole episode is about 2 weeks.

Moderate Depressive Episode

At least two of the three most typical symptoms noted for mild depressive episode should be present, plus at least three (and preferably four) of the other symptoms. Several symptoms are likely to be present to a marked

degree, but this is not essential if a particularly wide variety of symptoms are present overall. Minimum duration of the whole episode is about 2 weeks.

Severe Depressive Episode Without Psychotic Symptoms

In a severe depressive episode, the sufferer usually shows considerable distress or agitation, unless retardation is a marked feature. Loss of self-esteem or feelings of uselessness or guilt are likely to be prominent, and suicide is a distinct danger in particularly severe cases. It is presumed here that the somatic syndrome will almost always be present in a severe depressive episode.

Presentation in Primary Care

Classically patients presenting to primary care do not always fulfil the criteria described above as many present with multiple somatic complaints (Guinness 1992, Al-Shammari et al 1993). There is often mixed anxiety and depression, a finding recently replicated in the New Zealand primary care study of depressive disorder (2003 **www.wnmeds.ac.nz/academic/psych/research/magie.html**).

Table 3

Common Presentation In Primary Care And Psychiatric Community Clinics (Adapted From Guinness 1992)

Somatic Symptoms

- Head: aching, heavy, crawling, pressure, "brain shrinking"
- "General body pain", abdomen, chest, bizarre pains, fatigue, malaise
- Autonomic symptoms: palpitations, fainting, dizziness, trembling
- Eyes: aching, watering, vision blurred
- Hands: in spasm, cannot write

Biological Symptoms

- Sleep: insomnia, bad dreams
- Appetite: poor

Affective Symptoms

- Anxiety: "thinking too much", irritable, angry, tense, fearful
- Depression: "unable to play", withdrawn from others, "heart sinking or sore" "low in spirit", foreboding
- Feeling haunted, possessed, bewitched, suicidal ideas

'Hysteria'

- Panic attacks and pseudo seizures
- Dissociative states

Cognitive Symptoms

- Self-expressed confusion, forgetfulness, poor concentration, falling asleep in class, poor retentivity.

Culture Specific Metaphor to Describe Depression Related Distress

- "sinking heart"
- "feeling hot"
- "gas"
- "heat in head"
- "biting sensation all over the body"
- "heaviness in the head"
- ghabdraat
- "nervios"
- "brain ache"
- "brain exploding"
- "shenjing shuairuo"
- "sadri dayeq alayaa" ("my chest feels tight")
- "tabana" ("I am fatigued")
- "jesmi metkasse" ("broken body")
- "I am a witch"
- "I am possessed"
- kafam bombos (my head is empty)

With globalisation and urbanisation there is an increasing need for the primary care physician to acknowledge the cultural dimension in the presentation of this illness in order to increase rates of recognition and treatment. The language and metaphor used to describe emotional states differs from culture to culture.

In primary care the consultation is central to diagnosis and engagement of the patient. If the metaphor used by doctor and patient differs then the outcome is likely to be affected resulting in either a poor diagnosis or poor concordance. Patients come into the consultation process with a set of assumptions about the illness that they are suffering from, based upon cultural norms and expectations. Such norms influence the value placed by society on mental health, the prevention of symptoms, illness behaviour, access to services, pathways to care, the way individuals and families manage illness, the way the community responds to illness, the degree of acceptance and support offered and the degree of stigma and discrimination experienced by the person with mental illness. The primary care physician needs to understand the cultural, religious and gender paradigm that the individual brings to the consultation in order to increase the chance of establishing a therapeutic alliance that reduces the personal distance between physician and patient. This will maximise the chance of therapeutic success.

In the UK, researchers have found that South Asian patients visit their general practitioner more frequently

than their Caucasian counterparts but are less likely to have depression diagnosed (Gillam et al 1980, Bhui et al 2001). This is thought to be due to the fact that South Asian patients present mainly with somatic rather than psychological symptoms. US studies show that primary care physicians are less likely to recognise depressive illness in African Americans and Hispanics. In Australia, Comino et al (2001) showed that general practitioners are less likely to make a diagnosis of depression in patients from the Asian population. A New Zealand general practice study (Arroll et al 2002) showed that if Maoris attend their GP, they are as likely to receive a diagnosis of depression as non-Maori but may not receive appropriate treatment. Reports from Italian, Lebanese, Turkish (Soykan & Öncü 2003) and African general practitioners show that depression is often poorly recognised in these cultures.

A common explanation for this under-recognition of depression is that somatisation and phrases that allude to physical sensations are a more likely presentation in people from non-western cultures. Patients from the Indian culture may use the words 'sinking heart', 'feeling hot' and 'gas' to communicate psychic distress (Bhugra et al 1997). Those from Nigeria describe 'heat in the head', 'biting sensation all over the body' and 'heaviness sensation in the head' (Ebigbo 1982) whereas Mexican Americans talk of 'nervios', 'brain ache', 'brain exploding' or 'uncontrollable' (Jenkins 1988). Chinese people describe 'shenjing shuairuo' (neurasthenia) (Parker et al 2001), those from United Arab Emirates 'sadri dayeq alayya' (my chest feels tight), 'tabana' (I am tired, fatigued) and 'jesmi metkasser' (broken body) (Sulaiman et al 2001), 'the heart is poisoning me', 'as if there is hot water over my back' and 'something blocking my throat' (see table 3). Turkish patients often complain of atypical facial pain, waking up tired in the morning, breathing difficulties (), kafam bombos (my head is empty) and sinirlerin bozulmasi (I've got shattered nerves) (Baarnheim & Ekblad 2000,Baarnheim 2004).

I. DIAGNOSIS OF DEPRESSION IN PRIMARY CARE

Depression is a common disorder in primary care and often presents in the context of physical disorder and multiple somatic complaints (as in table 3). A minority of patients present with a pure syndromal depression, as described in ICD10 and DSM IV (see tables 1 & 2). Whichever criterion is adopted, the symptoms and signs should be present nearly all the time for two weeks before making a diagnosis of depression. Patients who present with recurrent unexplained physical symptoms or illness could be suffering from depression. In contrast, treatment refractory patients with symptoms of depression may be suffering from an underlying undiagnosed physical illness. Depression can be co-morbid with physical illness and substance misuse.

Most patients seen in primary care have a social support network. A biopsychosocial approach is therefore essential as members of the social network can be used as allies in treatment. A detailed history taken over several appointments may be necessary.

Mental Health History Taking in Primary Care

- A longitudinal approach to history taking should be adopted in the primary care setting. The history should reflect the patient's early childhood and family, education, work, relationships, medical history, substance misuse including alcohol. It is particularly important to ask the patient about any past psychiatric history and any previous efforts at self-help and self-treatment.

- The information that you obtain should be understood in the context of the individual's cultural history, religious beliefs and taboos. As this takes time, it may be necessary to see the patient over a number of appointments. The patient should be encouraged to bring a relative or confidante to the consultation to provide support. This may allow for an added opportunity to gather added information that allows for a better understanding of the problem. If you already have case notes belonging to the patient, review them.

- It may be necessary to seek specific assistance from health workers of the same cultural group to better identify specific culture linked problems.

Mental Health Assessment

A useful framework for mental health assessment in primary care is that of **LOOK, LISTEN, TEST, (LLT).** This framework allows you evaluate the patient as a whole from the moment that they enter the consultation before applying a diagnostic label.

- First **LOOK** at the patient to assess their mood, their manner of dressing, their affective response, the type of eye contact (which may be culturally determined) and the quality of movements (i.e. slowed, agitated, restless).

- **LISTEN** to the patient in an empathic non-judgemental way. Note the volume of speech (i.e. quiet, normal or loud), the speed of speech (i.e. slowed, normal or increased in rate) and the content of the speech including the metaphors used. Note particularly the presence of suicidal ideas, delusions and hallucinations as this will allow you to assess the severity of the problem.

- **TEST** psychological functioning. Attention and concentration can be tested by asking the patient to repeat a name and address that you have asked them to memorise immediately and, after five minutes. You may also ask them to tell you the months of the year backwards. If you have any locally validated self-rating

questionnaire for depressive disorder (e.g. HAD scale (Zigmond & Snaith 1983), Zung Depression Scale (Zung 1965)) you should ask the patient to complete it.

- **TEST** for evidence of suicidal intent and hopelessness. You need to ask direct questions e.g. "Do you ever feel that life is hopeless?"; "Do you ever wish that when you go to bed at night you will never wake up?"; "Have you ever thought of ending it all by killing yourself?". If the patient answers yes to any of the above probe in more detail with empathy and sensitivity, as suicide is a taboo subject in some cultures. In some countries there are standard protocols to help family doctors assess and manage suicidal ideation and self-harm e.g. www.nice.org.uk/nsf/mentalhealth.htm. It is worth considering the factors in table 4 below when assessing whether a patient is likely to self-harm.

Table 4

Predictors of Suicide in Depressed Patients

a. Severity
b. Chronicity
c. Suicidal preoccupation & previous suicidal behaviour
d. Inappropriate or ineffective treatment
e. Associated chronic physical illness

Predictors of Repetition of Parasuicide in Depressed Patients

a. Past history of psychiatric treatment
b. Previous deliberate self harm
c. Diagnosis of a personality disorder
d. Problems with alcohol and substance misuse
e. Low socioeconomic group
f. Unemployment
g. Single status

- Adapted from Daly 1993

- **TEST** physical health by looking for clues for chronic illness and disability. Check the blood pressure in all cases because of the implications that this may have on your choice of pharmacological treatment.

- **TEST** the blood to rule out medical conditions that may mimic depression. Tests should include a full blood count (FBC), urea & electrolytes (U&E's), thyroid function tests (TFT's) and diabetes screening. Other physical investigations will depend upon the findings of the history & examination.

Table 5
SUMMARISE by answering the following questions:

a) Why have I made the diagnosis of depression?
b) What makes this person prone to depression?
c) Why has this person come to see me now?
d) What else do I need to know? Have I excluded a physical illness?
e) What are the cultural issues and taboos that I need to consider?
f) Who else can support the patient?
g) Who else can support me?
h) What treatment should I propose?
i) What advice should I give?
j) When should I see the patient next?

II. TREATMENT OF DEPRESSION IN PRIMARY CARE

Treatment of depression in primary care should be based on sociological, psychological and biological principles that respect the patient's individuality and engage them in partnership with the treating clinician. Treatment principles need to take into account the race, ethnicity, gender, religion, family and social situation.

It is well known that the response to psychotropic medication may be culturally determined. For instance Asians tend to report more side effects to psychotropics and tend to respond better to highly structured interventions such as cognitive behaviour therapy (CBT) (Lin & Cheung 1999). Likewise, patients of African origin tend to respond more favourably to structured interventions and the indigenous patients of Australia respond well to narrative therapy. The role of traditional and spiritual healers as co-therapists has been explored in Pakistan. This role has been found to be complementary to the traditional Western medical approach.

The primary care physician must use all available resources when planning the treatment intervention and must consider the role of stigma, employment and culturally acceptable behaviours. Strategies that respect cultural diversity are described in table 6 below.

Table 6

TREATMENT STRATEGIES IN PRIMARY CARE

A. SUPPORTIVE STRATEGIES:

Education
All patients presenting with depression should be provided with educational materials geared towards de-

stigmatisation and principles of diagnosis and management of depression. They should be encouraged to maintain their occupational links and family members and/or confidantes should be encouraged to act as co-therapists. Educational materials are available from local colleges, charitable organisations that deal with depression or on the internet (e.g. www.bluepages.anu.edu.au). Where available local opinion leaders should be encouraged to provide local educational materials relevant to the appropriate culture.

Exercise & Nutrition

The evidence to support the usefulness of exercise and good nutrition in depression is now accumulating. Exercise regimes may be as effective as psychotherapy. Encourage patients to go out for regular walks and where available consider a referral to the local gymnasium.

B. PSYCHOTHERAPY:

Counselling and psychotherapy is very useful for Westernised patients as they possess the language, metaphor and culture that allows them to make use of this treatment modality. Patients of African and Asian origin tend to respond better to cognitive behaviour therapy and more directive forms of counselling and psychotherapy (Lin & Cheung 1999). Narrative therapy has been found to be useful in the indigenous peoples in Australia and New Zealand. Dance and movement therapy have been found to be useful in elderly populations.

C. PHARMACOLOGICAL TREATMENTS

There is no room for the routine use of benzodiazepines in the treatment of depressive illness. Benzodiazepines should only be used short-term for insomnia and extreme agitation. Before prescribing you must discuss the risk of dependence and document that this discussion has taken place.

Antidepressants

65-70% of patients will respond to the first antidepressant given. The goal of antidepressant therapy is to remove symptoms, restore the patient back to their previous level of functioning and to prevent relapse. Selection of the type of antidepressant should be based on efficacy, safety, side effects and economic values. People from particular ethnic groups will respond differently to the drugs that they are prescribed. Antidepressant medication does not cause dependence and is not addictive and this needs to be highlighted to the patient. SSRI's (Selective Serotonin Re-Uptake Inhibitors) are not recommended for use in children and, if used in young adults they should be observed for signs of suicidality (www.mhra.gov.uk).

The majority of patients presenting to primary care physicians will need antidepressants to be augmented by non-pharmacological strategies for treatment of their depressive illness to be truly effective (Katon et al 1999). Helgason et al (2004) concluded that the use of antidepressant medication without other support has little effect on the prevalence of depression and its associated disabilities and complications. Whatever the cultural background of the patient the primary care physician should regard antidepressant medication as one element of the treatment plan for depression and not as the mainstay of treatment.

CHOICE OF PHARMACOLOGICAL TREATMENT

The choice of antidepressant should be tailored to the individual and to the local circumstances. A good assessment of the patient's mood state, psychosocial conditions, physical health and current medication combined with a knowledge of the properties of antidepressants from different pharmacological classes will inform your choice of agent. See table 7.

Table 7 **Properties Of Different Antidepressant Drugs**							
Anti-depressant type	Sedation	Weight	Sexual dysfunction	Seizure threshold	Heart rate	Blood pressure	Direct cardiac effects
Tricyclics (TCA's)	++ (varies with different TCAs)	↑	+	↓↓ dose related, particularly maprotiline	↑	Orthostatic hypotension ↑ BP in toxicity	+
SSRIs	±	Mainly ↓ & ↑	++	↓		–	–
MAOIs	±	+ phenelzine	++	–	±	+	–
Reboxetine	–	–	±		±	±	–
Venlafaxine	–	–	+	↓	+	↑(higher doses)	–
Trazodone	+	±	±	↓*	±	↓	–
Nefazodone	+	±	–	↓*	–	–	–
Mirtazapine	++	++	–	↓*	–	– ↓	–

↓* - low incidence

STRATEGIES FOR THE INITIATION OF ANTIDEPRESSANT TREATMENT

Pharmacological treatment is prescribed in three phases (Frank et al 1991):

1. Acute Treatment: Week 0-12 (To achieve control of symptoms & remission)

- Choose the antidepressant agent depending upon local availability and according to the properties that you require (see table 7)
- Gradually increase the dose to the maximum dose range according to side effect tolerability
- If remission is not achieved after six weeks at the maximum tolerable dose of the first choice antidepressant withdraw the medication and substitute a drug from a different class
- It is possible to train other primary care workers to monitor antidepressant treatment and to increase the patient's motivation for compliance. This could lessen the burden on the family doctor / primary care physician (Katon et al 1995, 1996).

2. Continuation Treatment: Week 12 – 46 (To maintain remission and prevent relapse)

- The antidepressant drug, which achieved remission should be continued in the same dose and supported by psycho-education which focuses on relapse prevention, feeling well and getting well.

3. Maintenance Treatment (Week 46 onward)

The need for maintenance treatment will be influenced by the known course of the individual patient's illness (past history of recurrence), by psychosocial factors (e.g. maintaining reasons for depression) and the patient's physical health.

- The antidepressant drug, which achieved remission should be continued in the same dose supported by psycho-education which focuses on relapse prevention, feeling well and getting well.

STRATEGIES FOR DISCONTINUATION OF PHARMACOLOGICAL TREATMENT

When you and the patient decide that it is appropriate to withdraw antidepressant medication do so carefully as unpleasant symptoms may occur on abrupt discontinuation of some pharmacological treatments. Abrupt discontinuation of tricyclic antidepressants (TCA's) can lead to increased cholinergic activity. Abrupt discontinuation of SSRI's could lead to dizziness, electric shock sensations, anxiety & agitation, insomnia, flu-like symptoms, abdominal spasms & diarrhoea, paraesthesia, mood swings, and nausea.

- Decrease the dose by 50% and review the patient every two to four weeks until the medication is withdrawn
- If previous symptoms re-emerge at any specific dose reduction either by clinical assessment or by using a locally available questionnaire revert to previous dose and do not attempt to withdraw drug for a further three to six months
- Review the patient four to six weeks after the medication has been fully withdrawn to confirm that they are maintaining full remission. Advise the patient on how to seek future help should depressive illness re-emerge.

OTHER CONSIDERATIONS

Occasionally patients treated with Serotonin Re-uptake Inhibitors develop a reaction to the medication called Serotonergic Syndrome (see table 8). Should this be suspected seek specialist help.

Table 8

Diagnostic Criteria for Serotonergic Syndrome

A. Coincident with the addition of or increase in a known serotonergic agent to an established medication regimen, at least three of the following clinical features are present:
   1. mental status changes (confusion, hypomania)
   2. agitation
   3. myoclonus
   4. hyper-reflexia
   5. diaphoresis
   6. shivering
   7. tremor
   8. diarrhoea
   9. inco-ordination
   10. fever

B. Other aetiologies (e.g. infectious, metabolic, substance abuse or withdrawal) have been ruled out.

C. A neuroleptic had not been started or increased in dosage prior to the onset of the signs and symptoms listed above.

III. ALTERNATIVE THERAPIES

Many patients in primary care, especially those from non-Westernised cultures also consult traditional and faith healers. It is therefore important to find out if your patient is receiving treatment from such healers. If so the healer should be engaged as a co-therapist. Confrontation should be avoided.

Often patients will consult alternative practitioners in parallel with the primary care consultation process (Lin & Cheung 1999, Baarnheim & Ekblad 2000) and this needs to be respected. Patients may seek support through self-help organisations such as **www.mind.org.uk** or **www.sane.org.uk** and this should be encouraged.

IV. SUPPORTING PROFESSIONALS

Primary care varies from country to country. Societies provide access to family practitioners with a specialist interest in mental health, practice nurses, clinical nurse specialists, psychiatric nurses, occupational therapists, social workers, health care workers, support workers, homelessness workers, housing officers, refugee support workers, self-help groups, village elders, voluntary workers from charitable organisations and access to leisure facilities. Where such facilities are available it is important to develop close working relationships with them and work together to develop strategies to defeat depression and remove stigma.

It is important to continue to improve your skills and knowledge of depression using a number of strategies. There may be locally available educational resources on the internet or in your local library e.g. **www.mentalneurologicalprimarycare.org** which you can access. You can develop an educational plan that targets gaining knowledge and expertise in depression either by regular attendance at case conferences, self–directed learning groups including Balint Groups (**www.balint.co.uk**), reading of journals and e-learning.

Remember – your patients are your best resource.

V. INDICATIONS FOR REFERRAL TO A SPECIALIST SERVICE

- Suicidal patient
- Psychotic depression
- Bipolar depression
- Co-morbid substance misuse
- Pregnant
- Children & adolescents
- Post natal depression / psychosis
- Failure to respond to two or more different antidepressant medications given at therapeutic doses
- Unclear diagnosis
- Patient who requires ECT
- Patient who requires augmentation of antidepressant with another pharmacological agent
- Severe psychosocial problems
- Doctor not coping or not feeling confident

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This guideline should not be construed as including all proper methods of care or excluding other acceptable methods of care reasonably directed to obtaining the same results. The physician in light of the circumstances presented by the patient must make the ultimate judgement regarding any specific clinical procedure or treatment.

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