

Best Practice

CASE-BASED REVIEWS

Depressive disorders in Asian American adults see also p 244

Mr S is a 25-year-old man who immigrated from China 9 months ago with the hope of attaining financial security and bringing his family to the United States. He comes to a primary care clinic with a 6-month history of severe fatigue and sharp, fleeting chest discomfort that occurs most often when he tries to fall asleep. He has become increasingly concerned about the meaning of this pain. His sleep is disturbed, his appetite is poor, and he has difficulty concentrating at work. He has been working as a waiter in a restaurant for 12 hours a day, 6 days a week since his arrival. He attributes his physical symptoms to long working hours.

When asked if these symptoms have caused him to feel sad or lose interest in his usual activities, he states that he no longer watches videotapes or spends time with his co-workers on days off because he just cannot concentrate and does not want to be a burden to his friends. He admits that he feels hopeless and desperate.

The findings of a physical examination and all laboratory investigations (complete blood cell count, serum electrolytes, thyroid function tests, liver function tests, electrocardiography) are unremarkable.

DEPRESSIVE DISORDERS IN ADULTS

Depressive disorders are a set of clinical syndromes characterized by distinct physical and psychological symptoms. These disorders can be divided into major forms, such as major depression or dysthymia (chronic and enduring lower intensity depression), and minor forms, including bereavement and adjustment disorder with depressed mood (see box 1).¹

INCIDENCE AND PREVALENCE

How common are depressive disorders in the general population?

For the general US population, the lifetime risk of major depression is about 7 to 12% in men and 20 to 25% in women.² About 5 to 10% of primary care patients have depression.³ Less than 50% of patients with depression, however, receive adequate treatment because of under-recognition and undertreatment.⁴ Of those people whose depression is diagnosed, more than half are treated by primary care physicians.

Summary points

- Because of cultural bias and stigma, Asians tend to view depression as a personal weakness or moral failing
- Primary care professionals should emphasize that having depression is a medical illness and is not indicative of such weakness
- Asian women have the highest suicide rate compared with rates for all other women in the United States
- When treating Asian patients, it is helpful to frame depression as a medical illness with signs and symptoms caused by a neurochemical imbalance in the brain
- Culturally competent communication with Asian patients with depression is critical for successful diagnosis and treatment
- Primary care practitioners have an important opportunity to reduce the stigma of depression by educating about and treating depression

How common are depressive disorders in Asian Americans?

Few studies of the prevalence of mental disorders in Asian Americans have been conducted. In a study in Los Angeles County, investigators found that the lifetime prevalence rate of depressive disorders in Chinese Americans is about 12.1% (6.9% major depression, 5.2% dysthymia), and the 12-month prevalence rate is about 4.3% (3.4% major depression, 0.9% dysthymia),⁵ both rates of which appear to be lower than that of the general US population.

The prevalence of depressive disorders in Asian Americans, however, may be underestimated because these patients often do not offer psychological complaints. In diagnosing depressive disorders, providers must specifically ask Asian Americans about such symptoms.

In other studies, researchers using depression-specific screening measures—such as the Center for Epidemiologic Studies Depression Scale (CES-D)—found that depressive symptoms in Asian Americans may be higher than in whites but lower than in Latinos and African Americans.⁶⁻⁸ A recent study performed in one primary care setting showed that 40% of Asians had significant depressive symptoms.⁹

ASSESSMENT AND EVALUATION

How do you evaluate depression in Asian American patients?

Ask about physical and psychological symptoms

Asian patients tend to present with somatic complaints (see p 253). Unexplained symptoms that have been investi-

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Box 1 Criteria for major depressive episode

- A Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either depressed mood or loss of interest or pleasure.
- Note: Do not include symptoms that are clearly due to a general medical condition, or mood incongruent delusions or hallucinations
- 1 Depressed mood most of the day, nearly every day, as reported by patient (eg, feels sad or empty) or observed by others (eg, appears tearful). Can be irritable mood in children and adolescents
 - 2 Reduced interest or pleasure in all or many activities most of the day, nearly every day, as reported by patient or observed by others
 - 3 Significant weight loss or gain (>5% of body weight in 1 month) or change in appetite nearly every day. In children, consider failure to meet expected weight gains
 - 4 Insomnia or hypersomnia nearly every day
 - 5 Psychomotor agitation or retardation nearly every day, self-reported and observed by others
 - 6 Fatigue or loss of energy nearly every day
 - 7 Feelings of worthlessness or inappropriate guilt nearly every day
 - 8 Indecisiveness or difficulty with thinking and concentration nearly every day
 - 9 Recurrent thought of death, suicidal ideation without a specific plan, or a specific plan for committing suicide
- B Symptoms cause clinically significant distress or impaired function socially and occupationally
- C Symptoms are not attributable to a general medical condition or use of a drug
- D Symptoms are not accounted for by bereavement; persist for more than 2 months; and are characterized by suicidal ideation, psychotic symptoms, psychomotor retardation, and morbid preoccupation with worthlessness

gated or treated in other settings and that remain unresolved should be considered “red flags” for further probing. In one study, Asian American patients with symptoms of major depression were at greater risk of having their primary care provider miss their symptoms than were Latino patients.⁹ This was true even when physicians and patients spoke the same language and were of the same ethnicity.

A list of phrases commonly used by Asian Americans that potentially indicate their underlying depression is provided in the Figure.

There is no consensus on how to conduct routine screening for depression in primary care. A sensitive method to screen for depression, however, is to ask the question, “For the past 2 weeks, have you had depressed mood or lack of interest or pleasure in usual activities?”¹⁰ This question is based on the diagnostic criteria of depressed mood and anhedonia.¹ The criteria have been translated into Chinese as part of a large-scale study of the

elderly. Other translations are available from the World Health Organization (www.who.int).

We recommend that physicians learn to ask these questions in the patient’s vernacular, enlisting the help of a skilled, culturally aware interpreter who can develop the questions and frame them as important for determining an accurate diagnosis.

Elicit psychiatric and medical history

This part of the assessment should include particularly any history of depression, anxiety, and substance abuse. About 50 to 85% of individuals who have had one episode of major depression will suffer another episode.¹¹ Alcohol abuse may cause or worsen existing depression. Anxiety disorders may coexist with depression. In addition, untreated anxiety disorders can often lead to recurring depression. Finally, chronic diseases, such as coronary artery disease, diabetes, or asthma, can increase the risk for depression.^{12,13} Unfortunately, no culture-specific data are available.

Determine risk factors for depression

The risk factors for depression are:

- Bereavement
- Female gender
- Divorce
- Job loss
- Low socioeconomic status
- Lack of social support
- Social isolation

Assess the patient’s functional impairment

The focus of these questions to the patient is to determine whether and how the symptoms they describe have caused physical, social, or role impairment. For Asian Americans, who typically underreport their mood symptoms, a visible and persistent decrease in the level of function can be an important motivating factor for depression treatment. Although Asian Americans may not volunteer loss of functioning readily because of shame or “loss of face,” obtaining historical information from family members can be helpful.

Assess suicidal ideation

Research findings from the past four decades consistently indicate that Asian women have the highest suicide rate compared with all other women in the United States.¹⁴⁻¹⁶ Asian American women between ages 15 and 24 and 65 and older are particularly vulnerable compared with women of other racial and ethnic groups in the same age range.¹⁶

<u>Chinese</u>	<u>Japanese</u>	<u>Korean</u>	<u>Vietnamese</u>	<u>English Equivalent</u>
壓力	ストレス	압박, 긴장	Áp lực	Stress
緊張	神經過敏	신경과민	Cẩn trọng	Nervous
疲倦	疲労感	피로감	Mệt	Tired
睡不好	不眠	불면증	Ngủ không ngon	Poor sleep
吃不好	食欲减退	식욕감퇴	Ăn không ngon	Poor appetite
心裏煩悶	苦悶感	번민, 속태움	Tâm thán buồn hiu	Bothered, annoyed
發愁	心配	근심걱정	Lo lắng	Worried
發瘋	發狂	광증	Điên điên khùng khùng	Crazy
坐立不安	不安感	불안감	Không đủ nghĩ ngơi	Restless
消沉	憂鬱	우울	Ám trầm	Feel low
孤獨	孤独感	외로움	Cô độc	Lonely
傷心	悲哀感	슬픔	Buồn	Sad
愛發火	焦燥感	초조감	Nóng nảy	Irritable

East Asian idioms of distress

Committing suicide in many Asian cultures is considered an immoral and disrespectful act to one's parents and ancestors. Many Asian patients with depression will express passive suicidal thoughts when questioned sensitively. Phrasing the question by saying: "Other patients with these symptoms sometimes lose hope, do you have thoughts of giving up?" avoids confrontational statements and the shame that patients feel about having suicidal thoughts.

Health care providers must probe further for suicidal intent and plans. Suicidal thoughts are part of the depressive illness, and inquiry about suicide will not provoke suicide in depressed patients. Asian patients and families often deny previous suicide attempts for fear of shame and stigma. We ask frequently about any unusual injuries or accidents that have occurred to family members as a proxy for possible suicidal or parasuicidal behavior in the patient's relatives.

Assess medical history and medications

Several medical conditions may be associated with depressive symptoms (box 2). The use of some medications, including some herbals, alcohol, and illicit drugs, can also trigger symptoms of depression. Because some East Asian (Chinese, Japanese, and Taiwanese) physicians commonly prescribe benzodiazepines to treat symptoms of anxiety



The suicide rate in Asian American women is higher than the US average for women of other races

Box 2 Medical disorders commonly associated with depression

- Cancer
- Chronic fatigue syndrome
- Chronic pain
- Coronary artery disease
- Endocrinologic conditions
 - Hyper and hypothyroidism
 - Diabetes mellitus
 - Cushing's syndrome
- Hemodialysis
- HIV infection
- Neurologic disorders
 - Stroke
 - Parkinson's disease
 - Multiple sclerosis
 - Epilepsy
 - Huntington's disease
- Dementia

associated with depression, many recently immigrated Asian patients have been taking large doses of benzodiazepines for long periods. Such long-term use can trigger or worsen depressive symptoms and also can increase the risk of physical dependence.

Examine the patient

The mental status examination

Impaired concentration with a sad (dysphoric) facial expression is common in depressed patients. Depressed patients can appear to be either restless or slowed down. If psychotic symptoms (delusions and hallucinations) are present with depressive symptoms, a likely diagnosis is major depression with psychotic features or possibly a primary psychotic disorder with secondary depression. Hearing reassuring voices from deceased ancestors, however, may reflect a culturally sanctioned adjustment and not psychotic ideation. Nonetheless, all patients who hear voices should be referred to a culturally competent mental health professional for further evaluation.

Physical examination and laboratory investigations

Information gathered from these evaluations rules out any obvious physical causes of fatigue, anxiety, or weight loss, such as anemia, hyper- or hypocalcemia, diabetes, thyroid disease, syphilis, and HIV infection.

What is the differential diagnosis of depressive disorders?

The differential diagnosis includes the following:

Bipolar (manic depressive) disorder

Patients with bipolar disorder may present with depression or with depressive symptoms in mixed manic states. Typically, however, they have had mania or hypomania (periods of sustained elevated mood or irritability with lack of need for usual sleep). These patients should be referred for psychiatric consultation or should receive a mood stabilizer, such as lithium or valproate, at therapeutic doses before initiating a regimen of antidepressant medication to decrease the risk of developing mania.

Anxiety disorders

Patients with anxiety disorders (panic disorder, obsessive compulsive disorder, posttraumatic stress disorder, generalized anxiety disorder, social anxiety disorder) may present with symptoms of irritability, nervousness, insomnia, and diminished concentration. If the anxiety disorder is not treated effectively, these patients can further develop depressive symptoms because of impaired functioning. We have noted that most Asian patients presenting in the primary care setting have prominent anxiety symptoms that coexist with depression or may be representative of the patient having more than one psychiatric disorder (eg, depression and posttraumatic stress disorder).

Dementia

As many as 40% of patients with dementia may also experience symptoms of depression. A trial of antidepressant medication can be helpful and may improve the patient's functional level (see p 271).

Psychotic disorders

Psychotic disorders can be accompanied by depressive symptoms. For example, patients with schizophrenia can suffer from depression, which responds to antidepressant treatment.

TREATMENT

Medication and psychotherapy

Depression is treated with antidepressant medication (see Medicine Cabinet, p 271) and psychotherapy. In explaining the need for treatment to the patient, depression should be framed as a medical illness with specific signs and symptoms caused by a neurochemical imbalance in the brain. This approach helps the patient to see that you appreciate the holistic view of health and wellness that is part of the patient's belief system.

Education

Even if patients refuse to engage in formal psychotherapy or psychiatric treatment, they might be amenable to using more indigenous forms of treatment. Pastoral counseling, acupuncture, and peer counseling are low cost, comple-

Other depressive syndromes

Bereavement. This psychological, physiologic, and behavioral reaction occurs in response to the death of a loved one. Some grieving patients present with symptoms of depression. Although acute grief symptoms can mimic or overlap those of major depression, bereavement can be distinguished from depression on the basis of the following features:

- Onset of symptoms within 2 months of death of a loved one
- Less than 2 months duration of symptoms
- Symptoms associated with "triggers" resolve
- Functional impairment is brief and mild to moderate
- Normal self-perception

If a grieving patient's symptoms remain undiminished after 2 months and meet criteria for major depression, then aggressive treatment, including counseling and medication, should be considered.

Adjustment reaction with depressed mood. Sad feelings can be appropriate responses to life stressors. When the reaction appears excessive or continues for longer than 2 months but does not meet the criteria for another mental disorder, the diagnosis of an adjustment reaction with depressed mood is likely.

mentary forms of treatment that may be helpful and generally are not harmful. There is evidence of therapeutic benefit only for acupuncture.¹⁷

Patients should be cautioned gently about using large quantities of herbal pharmaceuticals, particularly herbs in concentrated pill forms. These products may contain toxic ingredients, such as lead and arsenic, which may worsen symptoms. At the same time that they are prescribing antidepressant medication, however, primary care providers can show an understanding of patients' attempts to seek alternative health treatments. This willingness to consider various treatment methods helps to maintain the possibility of referral to a mental health professional (see below). This sensitive approach also sustains an alliance without the patient feeling rejected and then in turn rejecting further help.

REFERRAL TO A MENTAL HEALTH SPECIALIST

Referral is considered for:

- Suicidal risk
- Need for inpatient psychiatric treatment
- Failure to respond to adequate trials (6 to 8 weeks at maximum tolerated doses) of two different antidepressants
- Signs of bipolar illness or the presence of hallucinations, delusions, or severe psychomotor retardation
- Presence of another medical or psychiatric illness that complicates the treatment
- Need for psychotherapy

- Evaluation of current pharmacotherapy
- Severe personality disorder that interferes with the treatment or with patient adherence
- Patient's request

Referral of Asian patients to a mental health specialist can be difficult because of patient stigma, the view that seeing a psychiatrist connotes "craziness" or severe disease, concerns of confidentiality, the belief that "just talking will not help," lack of insurance, and the dearth of culturally and linguistically competent professionals. Important points for the primary care provider to stress are continued involvement with the care even after referral and, with the patient's consent, a willingness to share helpful information about the patient with the specialist. These two steps, although seemingly minor, can increase the chances of a successful referral. In addition, arranging the introduction of the patient to the mental health professional can facilitate and demystify the referral. Finally, explaining that treating depression is a treatment of "mind and body" helps to exploit an acceptable cultural context for referral.

The findings of the medical work-up were discussed with Mr S. His physician discusses the possibility that Mr S's physical symptoms are due to an underlying depression. Mr S is surprised and refuses to accept this diagnosis. He declines to see a psychotherapist but agrees to take medication for his fatigue and sleep disturbance. The physician prescribes therapy with a selective serotonin reuptake inhibitor, expressing confidence that if Mr S takes his medication on a daily basis, he will improve in the second or third week of treatment.

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