Brazil: world leader in anxiety and depression rates

On February 23, the World Health Organization (WHO) published a survey[1] on the two most common psychiatric illnesses affecting the world population: depressive and anxiety disorders. According to this survey, Brazil leads the world in prevalence of anxiety disorders and ranks fifth in depression rates.

Surveys of this kind are highly relevant, as they are often the basis of actions by the government and society and serve as guides for public policy-making for prevention and/or treatment. Whatever the use and attention that the data from this survey might have in the future, some reflections seem timely for an informed debate on this topic.

Compared to the preceding survey, released in 2005,[2] the latest WHO report describes an increase in the frequency of both depressive and anxiety disorders worldwide, pointing to population growth and increased longevity as contributing factors for the current picture. Although the latter factors are always involved in discussions about the prevalence of any disease, other potential confounders must be taken into account in this debate, including methodological discrepancies in diagnosis and data recording across countries, cultural differences in help-seeking behaviors, and differential availability and organization of mental health services, to name a few.

In 2007, the *British Medical Journal* invited two eminent researchers to answer the question "Is depression overdiagnosed?" in their section "Head to Head." Advocating that depression is overdiagnosed as a result of the medicalization of sadness, Parker[3] stated that "a low threshold for diagnosing clinical depression [...] risks normal human emotional states being treated as illness, challenging the model's credibility and risking inappropriate management." In the opposite direction, Hickie[4] wrote at the time that "From a health and economic perspective, we can give a clear answer – more adults are alive and well, and we can easily afford to treat more." Both authors supported their views with solid evidence.

Whatever the precise extent of the problem in Brazil and around the globe, it is already a collective issue, and the personal and financial burden of anxiety and depression demands prompt and coordinated action from the scientific community and government agencies.

In order to answer some of the questions raised by the WHO reports on mental health, research efforts should be directed to three main targets: 1) furthering our understanding of the etiological factors of anxiety and depressive disorders; 2) elucidating their social, cultural, and geographic determinants and impacts; and 3) increasing diagnostic and therapeutic accuracy. If the spread of these disorders is not checked – whether through preventative or therapeutic action – and the needs of affected individuals are not met, the productivity and social-security systems of many countries could be seriously jeopardized in the near future.

Ildebrando Moraes de Souza,[1]
João Paulo Machado-de-Sousa[2]
[1]*Tribunal de Justiça do Estado de São Paulo, Cravinhos, SP, Brazil.*
[2]*Faculdade de Medicina de Ribeirão Preto, Universidade de São Paulo (USP), Ribeirão Preto, SP, Brazil*

Disclosure

The authors report no conflict of interest.

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Schedule for Affective Disorders and Schizophrenia for School-Age Children – Present and Lifetime Version (K-SADS-PL), DSM-5 update: translation into Brazilian Portuguese

The use of structured and semi-structured diagnostic instruments allows objective assessment of DSM categories by professionals involved in child and adolescent mental health evaluation, which has been essential to the advancement of clinical and epidemiological research in the field. Over the years, several semi-structured diagnostic instruments have been developed and tested for reliability and validity, such as the Diagnostic Interview for Children and Adolescents (DICA)[1]; the Development and Well-Being Assessment (DAWBA)[2]; and the Schedule for Affective Disorders and Schizophrenia for School-age Children (K-SADS).[3]

The K-SADS is among the most widely used instruments in child and adolescent psychiatry. The first version was the K-SADS present state (K-SADS-P), developed by J. Puig-Antich and W. Chambers in 1978. Updates

and adaptations were published in the following decades: the K-SADS-P IIIR in accordance to DSM-IIIR criteria, as well as the K-SADS epidemiologic (K-SADS-E), which collects lifetime diagnoses for epidemiologic purposes. After publication of the DSM-IV in 1994, Kaufman, Birmaher, Brent, Rao, and Ryan introduced the K-SADS present and lifetime version (K-SADS-PL), which was the most comprehensive version developed to date.[3] The K-SADS-E and K-SADS-PL have been translated into Brazilian Portuguese, and have been used extensively by researchers and clinicians ever since.[4,5]

In 2013, the American Psychiatry Association launched the fifth edition of the DSM, with relevant changes to the psychiatric classification of disorders affecting children and adolescents.[6,7] Soon after, a revised version of the instrument (K-SADS-PL-DSM-5) was developed to keep the instrument up to date with the new classification system. However, this instrument has not yet been translated into Brazilian Portuguese, hindering the advancement of child and adolescent psychiatry research in the country. On that account, we endeavored to translate the revised K-SADS-PL-DSM-5 from English into Brazilian Portuguese.

In this letter, we describe the careful process of translation of the latest version of the K-SADS-PL, now updated according to current DSM-5 criteria (K-SADS-PL-DSM-5), for use in Brazil. We invited specialists in each diagnostic area covered by the instrument (Table 1) to translate the respective section. The entire text was then revised by two child and adolescent psychiatrists (TBR and CK) and standardized by an independent professional (RK, a pediatrician and child neurologist with a background in linguistics). Subsequently, the translators of each area approved the final version of the document.

We regard this as a much-needed and relevant accomplishment, which should be followed by validation of this translated version. Scientific research is asymmetrically scarce in low- and middle-income countries,[8] where the health demands of children and adolescents are mostly unmet.[9] While many factors operate in this equation, we believe that the availability of up-to-date translated and validated versions of psychometric instruments used worldwide is an important step towards equality of means.

Disclosure

Table 1 Diagnostic categories covered in K-SADS-PL-DSM-5

Depressive and bipolar related disorders
   Depressive disorders
   Mania
   Disruptive mood dysregulation disorder

Schizophrenia spectrum and other psychotic disorders
   Psychosis

Anxiety, obsessive-compulsive, and trauma-related disorders
   Panic disorder
   Agoraphobia
   Separation anxiety disorder
   Social anxiety disorder and selective mutism
   Specific phobia
   Generalized anxiety disorder
   Post-traumatic stress disorder
   Obsessive-compulsive disorder

Neurodevelopmental, disruptive and conduct disorders
   Attention-deficit/hyperactivity disorder
   Oppositional defiant disorder
   Conduct disorder
   Tic disorders
   Autism spectrum disorder

Eating disorders and substance-related disorders
   Eating disorders
   Tobacco use disorder
   Alcohol use disorder
   Substance use disorder

Others
   Enuresis
   Encopresis

Arthur Caye,[1] Renata R. Kieling,[2] Thiago B. Rocha,[1] Ana S. Graeff-Martins,[1] Cristiane Geyer,[1] Fernanda Krieger,[1] Gisele G. Manfro,[1] Helena Brentani,[3] Luciano Isolan,[1] Maria C. Rosário,[4] Rodrigo Grassi-Oliveira,[5] Sheila C. Caetano,[4] Tais Moriyama,[6] Luis A. Rohde,[1] Christian Kieling[1]

[1] Departamento de Psiquiatria, Faculdade de Medicina, Universidade Federal do Rio Grande do Sul (UFRGS), Porto Alegre, RS, Brazil. [2] Departamento de Pediatria, Faculdade de Medicina, UFRGS, Porto Alegre, RS, Brazil. [3] Departamento & Instituto de Psiquiatria, Faculdade de Medicina, Universidade de São Paulo, São Paulo, SP, Brazil. [4] Departamento & Instituto de Psiquiatria, Faculdade de Medicina, Universidade Federal de São Paulo, São Paulo, SP, Brazil. [5] Developmental Cognitive Neuroscience Research Group (GNCD), Pontífica Universidade Católica do Rio Grande do Sul, Porto Alegre, RS, Brazil. [6] Centro Integrado de Desenvolvimento da Infância e Adolescência, Instituto Bairral de Psiquiatria, Itapira, Brazil

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