Brazil: world leader in anxiety and depression rates

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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.

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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

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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.

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

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