Culture and depression

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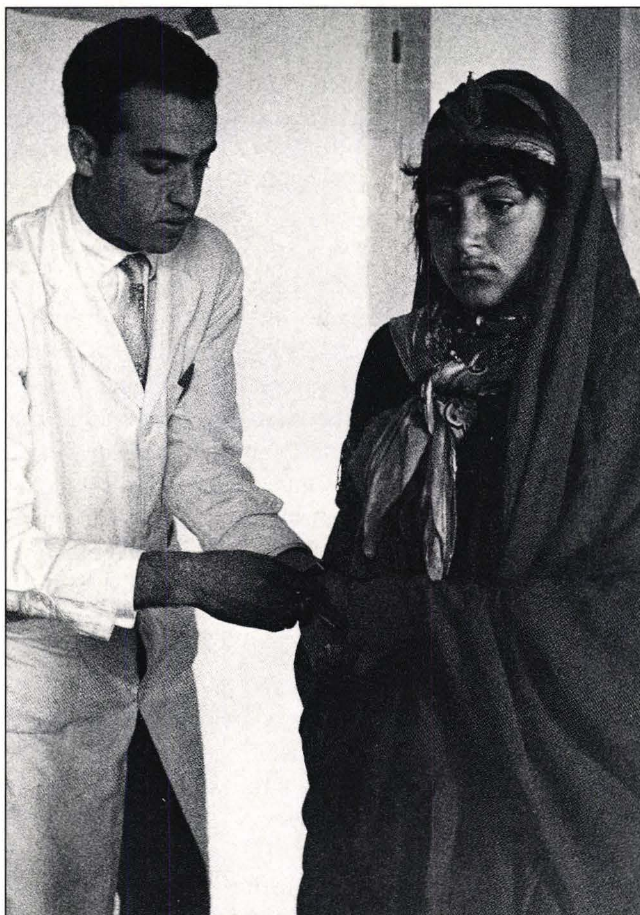


In devoloping countries, depression is seldom diagnosed as such and tends to use the language of the body to express itself.

Each year, at least 100 million people around the world develop a depressive illness. This number will in all probability increase as a result of lengthening life expectancy in most countries, and of the socioeconomic and cultural changes which expose more and more people to acute or prolonged psychosocial stress. It may also be, however, that the frequency of depression is increasing in the younger generations. Uprooting, the disintegration of the family, social isolation and other such phenomena can cause depressive reactions. The spread of certain somatic pathologies also increases the risk of depression, with greater consumption of alcohol and the abuse of a whole range of drugs which hasten the onset of depression or accentuate its intensity (see *Depressive disorders in different cultures*, by N. Sartorius et al., WHO, Geneva, 1983).

The scale of the problem is certainly of great public health importance, especially since effective treatments exist. But patients who suffer from depression usually receive no treatment, especially in the developing countries, and as a result are exposed to quite unnecessary suffering which in turn also affects the family and the community.

Access to appropriate care for depressed patients is particularly limited by misconceptions about this disorder, which result in many diagnostic and therapeutic errors. The case of Mrs M. typifies this problem. Following the accidental death of her son, this 48-year-old woman of Maghreb origin started to suffer from insomnia, fatigue and violent headaches which normal analgesics could not cure. After she had had a long series of medical consultations with neurologists, ophthalmologists, and ear, nose and throat specialists, a dentist blamed tooth decay. She had all her teeth extracted and replaced by a false set, but this did nothing to improve her headaches – on the contrary, they got worse. Wearily, the dentist sent her to a psychiatrist who diagnosed an underlying depression. The diagnosis was confirmed by her total cure from all the symptoms, including headaches, once antidepressive treatment was started.

Do symptoms of depression differ across cultures?

Back in 1904, the German psychiatrist Emil Kraepelin, who laid the foundations of modern psychiatry by defining the basic morbid symptoms in terms which remain essentially valid today, wrote after travelling to several countries: "The descriptions of mental illness that figure in our classical reference books and manuals are based on the observation of Western mental cases, but the symptoms seen in other countries are often different".

It has been widely demonstrated since then that culture affects not only the incidence of depressive illness but also the manifestation of symptoms and the evolution of the disease. For example, in Western countries depression is verbalized in terms of mental suffering, sadness, despair or pessimism, whereas in African or Eastern societies moods often appear to be described in the language of physical symptoms, translating the suffering of the spirit into bodily terms. A wide range of ailments, such as headaches, stomach

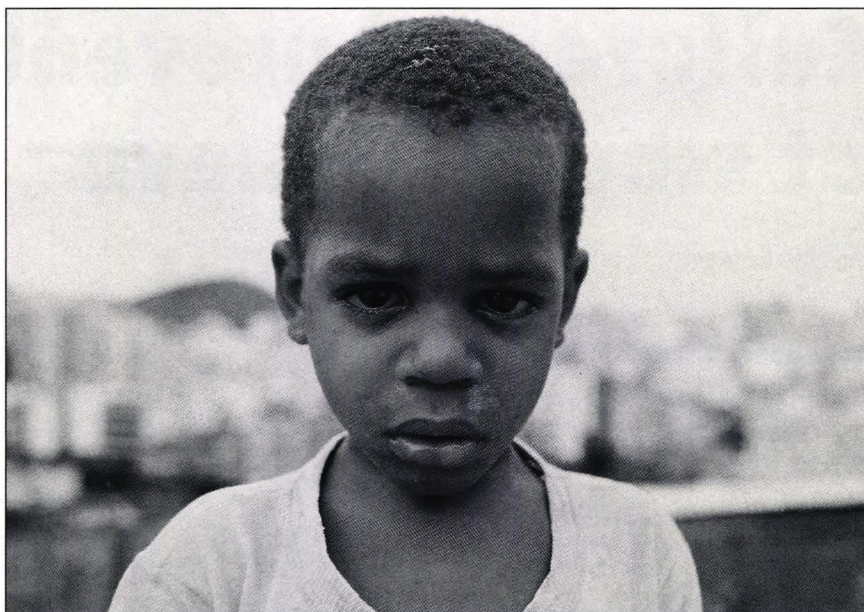
upsets or back pain, as well as the fear of illness and death, will express the feeling of being unwell and wanting to die that is inherent in depression.

Changing clinical profile

Recent studies have shown evidence of a definite change in the clinical profile of depressive states. This is directly related to the profound social, economic and cultural changes that the developing countries are undergoing. An epidemiological inquiry made among the general public in Tunisia in 1995 found, in a sample of 5000 persons, prevalence rates of depression that were entirely comparable with those of the industrialized countries. It does seem as if "Western-style" depression is becoming common in parallel with socioeconomic development, urbanization and the consequent dislocation of traditional community structures.

Yet although the environment colours the symptoms of depression, it never radically alters the basic structure or dynamics of this condition. So alongside the manifestations that are proper to a given culture, one finds certain common non-specific characteristics which seem to be universal: a fundamental change of mood, a diminution of interest and initiative, a lack of enjoyment of life, sleeping troubles, and loss of appetite or libido. Thus in a WHO study (1983), 76–100% of the patients in all four countries involved (Canada, Islamic Republic of Iran, Japan, Switzerland) showed a core of depressive symptoms comprising "sadness, lack of joy, anxiety, tension, lack of energy, lack of interest, loss of concentration, and feelings of inadequacy, incapacity or loss of esteem".

Although prevalence rates may vary, it is incontestable that depression appears everywhere in the world and that depressive patients constitute an important percentage – perhaps even a majority – of individuals requiring or requesting mental health treatment.



A child in a Rio favela. The depression caused by poverty may lead the sufferer into drug abuse and criminality.

All the same, because psychic suffering is a subjective experience expressed in the individual's own language and personal history, culture can affect the evolution and communication of depressive symptoms. The risk of underestimating their importance or of making diagnostic errors can be reduced by a better knowledge of cultural influences. That knowledge is all the more important at a time of great cultural intermingling in all countries, since it will help to highlight, over and above the differences, the shared characteristics that must be recognized if therapeutic knowledge is to make progress. ■

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A recent WHO survey in general health care settings in 14 countries[a] confirmed that depressive disorders were the most common mental disorder among primary care attenders. On average 10% of the primary care attenders had a "current" depression although rates varied depending on the health care setting.

It was shown that all core symptoms of depression, as defined in the *International Classification of Diseases*, 10th revision[b], were observable in different cultures. There was little difference between the so-called "bodily" (physical) and "emotional" (psychological) expressions of depression across different cultures.

The study showed that only half of these patients were recognized as cases and only a quarter of them were given treatment. This provides an intriguing insight into the dimensions of this major public health problem. Depression is highly prevalent. It is, however, often neither recognized nor treated, although effective treatment exists.

[a] *Mental illness in general health care. An international study, by T. B. Ustün & N. Sartorius, 1995, is available from John Wiley & Sons Limited, Baffins Lane, Chichester, West Sussex, PO19 1UD, England.*

[b] *The ICD-10 Classification of Mental and Behavioural Disorders: clinical descriptions and diagnostic guidelines. Geneva, World Health Organization, 1992.*