Hong Kong Journal of Mental Health
2015, *41(1),* 15-23

Depression Across Cultures - Issues and Management

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Personally I'm indebted to Prof. P.M. Yap because he was the first psychiatrist who described culture bound syndromes. Over the years I have read about culture based syndromes and I disagreed that they exist. I have changed. But its impact on cultural psychiatry has been absolutely phenomenal. The reason why cultural formulation won't have happened without his vision and without his input in looking at cultural factors and how they impact upon presentation and treatments.

Cultures are heterogeneous

I want you to think about culture as a unique behaviour, lifestyle shared by a group of people which includes customs, habits, beliefs, values, laws which shape emotional behaviours and life patterns. Now, message number one - there is no such thing as a homogeneous culture. We all have micro-cultures, micro-identities which are to do with who we are, where we've been brought up, where we were born, where we work, where we trained, which university we went to, which hospital or which organisation we work in. Each of those has separate sets of cultural values. So one of the challenges for all of us when we are seeing a patient is that the patients come to us with micro-identities as well. Sometimes they will pass off those micro-identities because they don't want us to know what they think as a man, as a woman, as an older person, as a young person.

I'll come back to this question of micro-identity because that is absolutely critical when we talk about engaging with our patients. No two patients are ever alike even if they come from the same culture and I bet that Hong Kong is a collection of villages. Each building block has its own culture, its own norms, its own way of looking at things and behaving. But what is important about culture is what the culture teaches us how to think. That is a major factor that when we are born into a culture, the culture moulds the way we think, the way we have a world view, the way we see the world. And that changes once you've left home you go to university, depending on which university you are in, you'll have a different set of values, a different set of customs and rituals and so on and so forth.

It's also worth bearing in mind that there are cultural variations related to age, related to gender, related to religion, and any number of other factors. So when you see a patient, they're coming to see you with a set of expectations as you will be seeing them. Your culture is transmitted through enculturation - the way we are brought up. I remember many years ago when I was in India it struck me that children carry on playing till 9 o'clock or 10 o'clock, nobody says that 6 o'clock was time to go to bed. But whereas in Britain, it's 6 o'clock you have to go to bed, there isn't a negotiation. So what does that do to us, the way we think about boundaries and limits, the way we see the world. There are obviously, similarly there are other institutions and social systems which determine how we work, how we think, how we develop.

Transcript of Prof. P.M. Yap Memorial Lecture of 60th Anniversary Symposium on Mental Health on 8th December 2014.

Cultures are fluid

Message number two - cultures are fluid, cultures are not static. The culture that you are living in now is not the same as the culture you were born in however long ago it was. I know that certainly for me having been out of India for 30+ years. Every time I go back to India it surprises me how much the culture has changed. And part of me feels quite angry that's a culture has changed without my permission. And somehow I don't feel part of that and that is very important particularly in terms of migrations and migrants and otherwise but it's also this whole notion of assimilation and deculturation and how you get rejected by the majority culture.

I'll come back to that because acculturation is incredibly important. That's not necessarily a migration issue. It is also the fact that you move from one university to another, the expectations are very different, you are expected to hand in your essays, not multiple choice questions.

So there are those kind of issues, so you need to be aware of how you deal with the dominant culture to the extent that you become a member of that particular culture. It's worth bearing in mind that for all illnesses there are a specific explanations and this work has been taken from Meng-shing Tsang's work in Hawaii, who was a psychiatrist, a cultural psychiatrist. It appears that you have a supernatural explanation - an evil eye caused my illness, or that I did not pay homage to my ancestors and they are angry and that's why I have become ill. And then there are natural explanations - I haven't eaten something, I haven't done something and that's why I'm ill and so and so. Then there are medical explanations that my body's not working. And then there are some psychological explanations or a mixture of all of the above. And then there are social explanations. And what's quite interesting that when Meng-shing talks about that doesn't reflect some kind of evolutionary process, that culture evolves, you give up supernatural explanations and you get into more psychological mixture or social explanations.

What you need to bear in mind is that social explanations are incredibly important to patients and to all of us actually. That when you feel ill, depending upon how hypochondriac you are or how easy it is to get an appointment with the doctor, are you asked around, has anybody else had the same problem, when you have it what did you do, where did you go, what is the next step, what is the third step.

Some work done in America shows a symptom simply because America is largely private healthcare system, so people will avoid going to the doctor if they haven't got any insurance. So something like 70 to 90% of all illness episodes, though they have physical symptoms of heartbreak, are treated in personal, folk and family sector.

Cultures explain things

Message number three - there has been a few psychiatrists and psychologists who have argued that supervisors are psychologically inferior to psychologisers which is utter nonsense because everything depends on what your model says. If you think mind and body are linked together and something goes wrong in your mind or in body it will affect both. So you need to be careful in not pathologising people who present with psychosomatic symptoms saying there something psychologically inferior with them - there isn't. And it is that when you look at all these supernatural, natural, folk and professional explanations, very few professionals would believe in spirits or breaking taboo or evil eye or soul loss. Yes? Some would but not everybody.

Similarly disharmony - some professionals would, particularly in systemic approach of family health, they are not likely to believe

that this is your fate, that this is something you did in your previous birth that's why you're ill, it can't happen. Yes, noxious environment will agree and karmic law highly unlikely that professionals would accept. Similarly somatic-medical explanations that insufficient vitality folk would say 'I feel weak' and that's where in the work that Professor Yap did on culture bound syndromes and seeming loss of vitality becomes incredibly important because that's very, very common in Southeast Asia. Anyway if I sit in a clinic in India even now on any given morning I will probably see three or four patients who would complain of seeming loss in lively, seeming loss of depression and all that and so on and so forth.

There would be some kind of dysfunction, some kind of physiological imbalance which is where professionals and patients would agree and have. My father had it, my grandfather had it, my great grandfather had it, I have it, so professionals would believe that as well. There is a degree of overlap and common ground to say that's what happens. Similarly psychological explanations - fright - professionals would believe in anxiety, fright conundrum, excess emotion, slowness, too much thinking. But this is quite interesting that quite often patients complain that they have been thinking too much and it has slowed them, has made life very difficult for them to try and make decisions. Obviously there are social explanations in terms of cultural confusion and I'll come back to that because that's becoming increasingly important in terms of culture conflict, in terms of cultural bereavement and in terms of culture shock.

Disease and illness

Message number four - I want you to think about disease and illness. Disease is literally what it says 'dis-ease'. Part of the challenge for psychiatrists and doctors in general is that we are trained to identify, diagnose and manage disease which is a pathological entity, it has a very bio-medical formulation and an identifiable clinical picture and it's about diagnosis and generally it happens in modern health facilities such as clinics, hospitals, etc. But is it objective? I'll come back to that because we had a discussion earlier about depression - is it an objective diagnosis or not. Then there is some kind of scientific explanations for what's going on and specific treatment and the aim is to regain health.

On the other hand, illness is what patients are interested in. They want to know if I have this will I be able to work, will I be able to have a relationship, will I be able to go out with my children to play. And it is very subjective, it's a very personal, social, cultural formulation and it is a dysfunctional phenomenon and it is where patients go to see folk healers because folk healers and much more open to discussing what's going on rather than telling us that the appendix out. Faith healers would know why have you got a pain, how did it start, what happened, so there would be folk supernatural explanations and there may be symbolic/magical treatment which would alleviate suffering.

I want you to think about the last time you had a headache. Just think what you did when you woke up in the morning and had a headache and you said 'oh, my brain tumour has come back' or you said 'I drank too much last night' or 'there's a flu bug going around and I've got flu - I've got a headache'. Then you will decide whether you've got to take paracetamol, aspirin, ibuprofen or nothing. Because that allows you to understand from your previous experience when you have a headache what got you better, so you would use the same strategy or if you've never had it before you ask others - when you have a headache what did you do? And that's what I mean can be dealt with in personal folk social sectors. So subsequently when you have headaches the same process goes through your mind. Similarly when patients come to see us

and they've been hearing voices they've got a very clear explanation in their head that is what is causing the problem and that is what they need to do.

Cultural differences in depression

Cultural depression is not new, it was described in the 1st century A.D. Melancholia is an illness caused by visceral dysfunction, lowness of spirit from the single fantasy without fever. Patients were dull or stern, dejected, unreasonably torpid, become peevish, dispirited, sleep badly, and avoidance of haunts. Now it's worth bearing that in mind - the habit of the body in melancholia becomes perverted, the individual's colour becomes a darkish green, sleep does not rest them, bowels dried up, diffused watchfulness. All the symptoms of depression that you and I would recognise in clinical settings. Galen described it as malady that injures mind and is associated with profound depression and aversion from the thing that one loves best. Again you think of report in terms of response and also commissions.

Bright, who described kidney diseases - Bright's disease - also described two types of melancholia. One is where peril is not of the body but of the mind needing cure of the mind. And the second is not moved by any adversity present or imminent and no counsel of philosophy can calm those raging passions. So kind of primary and secondary depression in the 17th and 18th centuries. Richard Burton wrote Anatomy of Melancholy which included hereditary factors, the influence of childhood experiences, the nature of paranoid symptoms and the shifting phases of illness.

The reason why I'm showing you these is twofold. Firstly, the term melancholia means something, depression doesn't. And the reason depression doesn't is because it talks about as a very mechanistic experience that puts some pressure on you and your body as a machine is not functioning.

So there are descriptions that I would elaborate in traditional system 6th century B.C. Causes of illnesses related to the influence of gods and demons but also weather, environment, family, diet, religious taboos so a model ideology. And in 3000 B.C., two types of madness were described - endogenous and exogenous.

In Hindu scriptures both in Ramayana and Mahabharata, which are holy books, both describe family history of what would be, of what we would call depression - symptoms of grief, withdrawal, body changes colour, lack of energy, not being able to think clearly, loss of concentration.

This is quite an interesting story in Mahabharata, which is the second important scripture. The two families, there are a hundred cousins on one side, five cousins, five brothers on the other side. And for whatever reason there is always a war, and the war is about land, about property and so on and so forth. So Arjuna, who is the chief archer from one family, goes into the war, goes into the battlefield sees his relatives standing opposite him and panics. In a beautiful description of panic and depression - how can I kill them, they are my blood relatives. Lord Krishna, who's one of the Hindu reincarnations of supreme god, is a charioteer. So he takes him through what you and I would call a cognitive behaviour manual - that it's not about dying, it's not about death - a soul never dies, body changes, the soul will always be there. You're not killing them because it's just their body rather than individuals. And it is both, in terms of his cognition change and also as we would understand counselling - why are you worrying, this is not the end of the world.

So depression becomes much more of a preferred term as the body is seen as much more mechanical. That has its advantages and disadvantages and obviously there are issues with stress and depression, variations with

primary depression and secondary depression and endogenous depression and exogenous basically means they come from within, or it comes from outside which means something has caused it.

For a very long time, as I mentioned in the morning, there were misconceptions in Africa. British psychiatrists and anthropologists were very happy to note that there was no depression in Africa. They were all happy, clappy natives who never experienced depression because they obtained details collected from additions and asylums. So when you are in a crowded asylum and it's probably about 200 or 300 miles away from where you live, it's not going to be easy to go in and get a diagnosis if you are feeling depressed. It's also been shown in Arab countries that the rates vary between outpatients and populations. I'll come back to that because that is about help-seeking, where you seek help, what we see is causing our problem. And it is symptom clusters in different cultural groups are different.

There's absolutely no doubt in my mind that in many parts of India guilt as part of depression does not appear, shame does. And that has implications for back scholarative drive and how to deal with that. The Judaism concept of guilt is very, very different. So something that you need to bear in mind is that we know the depression is a symptom - I feel depressed. It's a syndrome - it could be any number of symptoms, not all, some or a majority. And the meaning varies from culture to culture - what does it mean? And, as I said earlier this morning, that many countries do not have words to describe depression as you and I would understand it. Unhappiness yes, sadness yes, feeling tired, feeling low, but not depression as we understand it.

Depression across cultures

So just to remind us, I'm talking about depressive illness here, I'm talking about abnormal mood states where changing mood is primarily compared with depressive symptoms. There are differences between major depressive and lesser minor depressive and less persistently low mood which is qualitatively different from unhappiness. And again the point that I made this morning, there's a danger in medicalising non-human emotions, so we need to be very careful about that. A loss of reactivity - nothing gives you pleasure, you can't feel happy because you're feeling low, and there's a diurnal variation in mood - maybe you feel better in the mornings, or you feel better in the evenings and a whole range of other things.

And minor depressive illness, the mood is low but it's variable. Obviously in major depressive illness there are symptoms of poor appetite, loss of weight, insomnia or hypersomnia, agitation, retardation, loss of pleasure. I think a loss of pleasure is incredibly important across cultures where people can tell you that I can't enjoy anymore. They may not have concern but again I think one of the challenges really is that when we talk about patients and depression - it depends upon the diet that you have and if you are in a high fibre, vegetarian diet you are less likely to experience those symptoms. So just to base your diagnosis on a single symptom is problematic. Poor concentration, suicidal intent, you look at appetite gain, weight gain and anxiety in minor depression.

So when we look at the depression across cultures I think these are some of the symptoms that we ought to look at. In some countries, as I said earlier, guilt is very important - I feel guilty, I've let everybody down. Or it would be - I brought shame to the family. So one is internal and one is external. Again we need to think about that. Obsessive compulsive disorder symptoms quite often vary across cultures because you are expected to do certain things, so you do that as part of your depressive symptom. Self-esteem takes a hit. Now one of the major challenges when we talk about self-esteem is how do we define 'self'.

And that goes back to the point I was making earlier this morning in that many cultures selfish social-centric self is not egocentric self. So when I'm harming myself, it may not be my body that I'm harming, although I'm taking that action, but the message is for my father, my mother, my wife, my daughters, etc.

So you need to think about what the concept of 'self' is. Obviously somatic symptoms will vary. Lots of Punjabi women will complain of 'my heart is sinking' and it's a very clearly defined metaphor. And it is like, I remember reviewing a paper of where they had translated 'butterflies in my stomach' and the woman couldn't understand what that meant because 'butterflies in my stomach' is such a British phenomenon. Similarly in Britain, when a patient comes to you and says I feel 'gutted', you know and I know what that means. You feel that your guts has been wrenched out, but that's not a physical feeling. It's a metaphor to describe, explaining and expressing your distress.

Obviously suicidal rates vary across cultures and again there are different reasons for it. But it's also worth bearing in mind that many cultures have very high suicide rates because it is perfectly acceptable. Now in Islamic countries suicide is proscribed by the Koran so the rates are not high. But we don't know that the rates are not high because in many countries in the old commonwealth suicide itself is prohibited so you never get the actual figures because families will do anything and everything they can to try and avoid admitting there's been a suicide. It was an accident, or somebody pushed him or something else happened. So we need to think very carefully about rates of suicide and suicidal intent which varies across cultures.

Epidemiology of depression

We talked a bit about epidemiology this morning. Lifetime morbidity is 9-18/1000 males and 22.4-28/1000 females. Prospective surveys of all types show that 85/1000 males and 177/1000 females. That just remind ourselves that women are two to three times more likely than men to have depression. It is partly that there are different levels of recognition and I will give you an example of why depression in a minute. People have different levels of awareness. They may not see depression as a condition and therefore they may not admit, or if they do they may see it as somehow a failure, lack of moral fibre. I don't know how many of you have been depressed because I have not seen you long enough. And perception of healthcare - where do I go for help. Again a number of individuals would go the priest or the church or the temple or the mosque or the boudoir because it's less sympathising. If you're going to the temple or the church three times a day, nobody is going to say why are you doing that because it is perfectly acceptable to go there and talk to somebody and get your social support system.

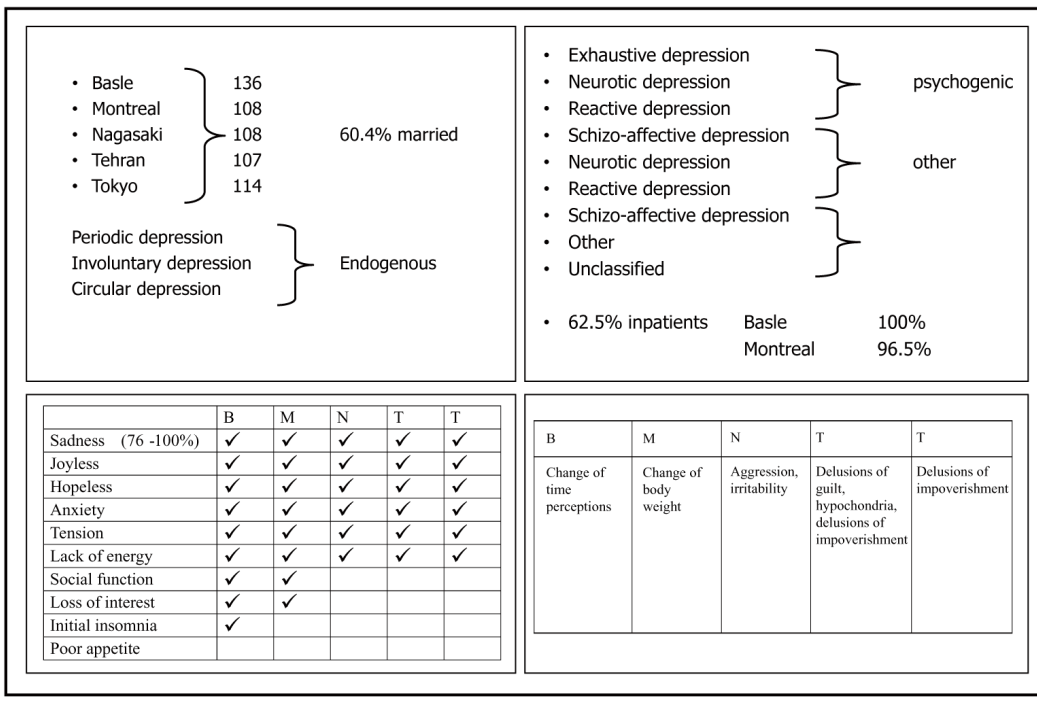
And lastly what we need to be aware of is that patients would use multiple pathways and medical pluralism. So they would get their St John's wart off the bat, they would get their present from you, they would go for their counselling from somebody else, they would go for their alcohol management somewhere else and four or five different things going on, so we need to be aware of that.

This is just one example of men - Foreign Student Syndrome (Ward, 1967). Students present in clinics quite often with vague non-specific physical symptoms. It's a kind of traumatisation but it's not. It's a passive withdrawn interaction, they're dishevelled, unkempt. And this is quite an old study (Still, 1961). It is that in one university 14% of British students had psychological problem, 28% were Iraqis, Iranians and Nigerians, and 22% Turkish and 18% from the Indian subcontinent.

We just finished a study in Brazil in sixth year graduate students something like 30% medical students had depression and nobody had gone to seek help because it would affect your career, it would affect your progression, and you can't get a job - why would you want to do that. And this was pure depression.

In a survey that we did on behalf of the Royal College several years ago, though we never published the data - there were problems with the data collection, something again, something like 36% were psychiatrists admitted to having had at least one psychiatric problem and the vast majority of them were self-medicating. So that tells us something about social expectations and it is worth bearing in mind if we take prevalence of treatable percentage (3-4%) in the general population - 1 in 5 seek treatment, 1 in 50 will enter hospital and 1 in 200 will commit suicide. Females to men for all depression is 2:1, bipolar is 1:1, MZ twins more likely than DZ twins (68% > 20%).

I want to spend some time talking about the SADD Study which Norman Zeporis led on. What they did was something very clever. They took five cities and looked at patients but took a very kind of qualitative way of looking at symptoms. So they had Basle, Montreal, Nagasaki, Tehran and Tokyo and they divided depression into periodic depression, involuntary depression and circular depression as endogenous. Neurotic and reactive depression was seen as psychogenic, and schizo-affective depression and neurotic depression under other. And going back to the point that I was making earlier about not having depression in Africa, 62.5% of patients in the study were inpatients - something that would never happen now. Basle had 100% and Montreal had 96.5%. But what's quite interesting is that if you look at all the cities sadness is top of the list everywhere - joylessness, hopelessness, anxiety, tension, lack of energy. Social function between Basle and Montreal but nowhere else and similarly loss of interest (Figure 1).



	B	M	N	T	T
Sadness (76 -100%)	✓	✓	✓	✓	✓
Joyless	✓	✓	✓	✓	✓
Hopeless	✓	✓	✓	✓	✓
Anxiety	✓	✓	✓	✓	✓
Tension	✓	✓	✓	✓	✓
Lack of energy	✓	✓	✓	✓	✓
Social function	✓	✓			
Loss of interest	✓	✓			
Initial insomnia	✓				
Poor appetite					

B	M	N	T	T
Change of time perceptions	Change of body weight	Aggression, irritability	Delusions of guilt, hypochondria, delusions of impoverishment	Delusions of impoverishment

Figure 1: SADD Study (n=573)

What does that tell us? Are we asking the right questions? What's also quite important that these authors found was that in Basle it was change of time perceptions, time went slowly. I wouldn't crack a stupid joke about Swiss watches and perception of time, but there is something else that's going on. Then in Montreal there were changes of body weight, Nagasaki was aggression and irritability, in Tehran delusions of guilt, hypochondria, delusions of impoverishment and in Tokyo delusions of impoverishment. So even within the same country you're getting a different set of symptoms.

And in Ghana again a small number of patients - sadness, joylessness, hopelessness, anxiety, lack of energy. So the core symptoms of depression (Jablensky, 1981) that we need to be aware of are sadness, joylessness, anxiety and tension, lack of energy, loss of interest, poor concentration, ideas of insufficiency, inadequacy and worthlessness. And this is quite an interesting study by Arthur Kleinman in Taiwan. Among the 100 contacted patients presented to the surgery psychiatry clinic, 93 had clinical depression of which 87 had major depressive disorder, one third melancholia. In 60% of the patients the symptoms had been there for more than two years, and a quarter had hysteria, conversion and panic, and 44 chronic pain. And interestingly these patients we are seeing are not depression which had some major issues in terms of management. 78% maintained wholly or partly organic disorder, 61% had work problems, 43% seen as communication distress. So 87 improved on antidepressants (6 weeks after 65% improved substantially, 17% slightly) but in one third the social impairment became worse because the psychiatrist had taken the idea that you had hysteria and now you have depression which was much worse. So again we need to think about how we do that. Similarly the WHO study in variation of depression in outpatients varies from 29.5% in Santiago to 2.6% in Nagasaki (Table 1).

Table 1
Transcultural variation in the Prevalence of Depression:
Results from the WHO Study[a]

Center	Current Depression **(%)**
Santiago, Chile	29.5
Rio de Janeiro, Brazil	15.8
Paris, France	13.7
Manchester, UK	16.9
Groningen,the Netherlands	15.9
Mainz, Germany	11.2
Bangalore, India	9.1
Athens, Greece	6.4
Berlin, Germany	6.1
Ankara, Turkey	11.6
Seattle,Washington, USA	6.3
Verona, Italy	4.7
Nagasaki, Japan	2.6
Shanghai, China	4.0
Ibadan, Nigeria	4.2
Total (male/female)	10.4 (6.8/12.4)

[a]Data from Goldberg and Lecrubier

In the UK there's a clear difference between different ethnic groups, between whites and African Caribbeans and Irish and Indians. It was found that Irish men, Indian females and Pakistani females show higher rates particularly those who were born in the UK or after early migration. The work of Furnham and Bochner (1986) on culture shock is quite important when people move from one culture, they may feel stressed in a sense of loss and rejection by the new culture. And it's an emotional reaction to an inability to understand, control and predict what's going on. On the other hand you get culture conflict - my own culture expects me to behave in a certain way, the new culture that I'm living in expects me to behave in a certain way and there's a quite clear conflict.

Perceptions of depression in Dubai

What we did was to determine perceptions of depression in the community, to develop what is called Emic form of questionnaire and to validate it. Emic is from within and Etic from outside. As I said earlier, we wanted to avoid a category fallacy. So we asked a number of native Arabic speaking people in focus groups to understand what they meant by depression, give them a vignette, understood their symptoms, their views on depression, causes, help-seeking, etc. And we got a series of symptoms which we then showed to clinicians and said when you are sitting in the clinic how many of these symptoms do you see. And from that we then go to the questionnaire and we ground it on 100 males and 100 females and various terms. I'm not going to go through that. Just to highlight the key messages that depression existed, causes were seen as social and management was seen as social rather than a medical one.

Cognitive factors for depression included a sense of entrapment and learned helplessness which is quite important and that we need to be aware of - you feel that somehow you can't get out of whatever you are trapped in. And out of entrapment is about aspiration versus achievement - what can I set out to achieve, could I achieve it. What's the dis-competency and that affects my self-esteem which affects my achievement, which affects my depression? So what we need to do is look at the symptoms, assess self-esteem, self-confidence, cultural identity, etc.

In the last two minutes or so I just want you to remember that pharmacodynamics vary across cultures, and pharmacokinetics also vary across cultures. Some cultures show very rapid metabolism and others show slow metabolism. Some cultures prefer capsules, others prefer injections, some prefer blue tablets, others prefer green tablets, others prefer red tablets and we haven't even begun to try and isolate what that means or what's going on in terms of peoples' compliance and engagement with us. So if your culture tells you that red tablets are better and you keep getting pale blue or pale yellow or other colours you may not like it.

So it is quite possible that in the next 15 or 20 years we will have more personalised drug therapies related to gene mapping. We will have gene maps on our mobile phones, we will plug into a computer and tell you that you'll have these side effects with this medication but not with that, and that's what you do. And similarly you need to check on complementary medicines when you start with your own medication. The difficulty with psychotherapies is that most psychotherapies are resident equal based therapies so you need to be very clear as to what kind of therapies you are doing. Some cultures can cope very well with therapies and others can't.

To conclude depression is universal; it is just that we haven't got the right tools to recognise it across all the communities and all the groups. The meanings and symptoms of depression vary dramatically and the explanations of why I am feeling depressed varies according to my culture, my age, gender, etc. And management strategies therefore need to be appropriate.

So once again, I'm delighted to be here and thank you very much for inviting me.