

Depression Across Cultures

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Introduction

Depression, or major depressive disorder, is one of the most commonly known disorders. It is fairly prevalent and it is a mood disorder (Shelton, 2018). It is characterized by “persistent feelings of sadness and hopelessness and (lost) interest in activities (they) once enjoyed” (Shelton, 2018, par. 1). The DSM-V provides the following criteria for diagnosing depression:

1. “Depressed mood most of the day, nearly every day,
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day,
3. Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day,
4. A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down),
5. Fatigue or loss of energy nearly every day,
6. Feelings of worthlessness or excessive or inappropriate guilt nearly every day,
7. Diminished ability to think or concentrate, or indecisiveness, nearly every day,
8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.” (Shelton, 2018, par. 3)

The DSM-V specifies that in order to be diagnosed, the individual must feel five or more symptoms (at least one of them being 1 or 2) throughout a two week period. The criteria in the DSM-V is not the only assessment that exists to determine the presence of depression. There are

numerous scales and inventories used in studies. The paper will begin by analyzing two of those scales, and how they are culturally limited. Following this, the paper will examine different aspects of depression across cultures, including the stigma associated with it, with the variance in symptoms that the stigma entails, as well as different cultural factors that affect the way individuals will experience and express depression across cultures. “Neuroscientists commented on the pervasiveness of ethnic and cultural issues in the interpretation of most genetic studies, and their influence on vulnerability and resilience, coping styles, cognitive responses to stress, and the nature of social support” (Alarcón, 2009, par. 41).

An analysis of standard depression symptoms across cultures was done, in which the Hopkins symptom checklist 15-item Depression scale (HSCL-15) was compared in different settings (Haroz, Bolton, Gross, Chan, Michalopoulos, & Bass, 2016). The participants included adults from low and middle-income countries (LMIC) from Colombia, Indonesia, Kurdistan Iraq, Rwanda, Iraq, Thailand, and Uganda (Haroz, et al., 2016). The 15 items in the scale were compared in all these countries.

The study’s purpose was to determine whether the varied prevalence of depression across countries was due to cultural factors or to errors in the measurement of the disorder in different settings. The researchers used Item response theory (IRT), to establish the scale’s cross-cultural applicability (Haroz, et al., 2016). The research finding’s concluded that most of the items in the scale are un-biased and that therefore, they are able to perform well in different settings (different countries and in different languages) (Haroz, et al., 2016). These items included: “feeling hopeless”, “feeling sad”, “feeling low on energy”, “problems with sleep”, “feeling trapped”, “worrying too much”, and “feeling worthless” (Haroz, et al., 2016). However, there

were two items that did present discrepancies. The item “loss of sexual interest or pleasure” is an indicator in Western countries, since sex is widely talked about and discussed. In non-Western countries; however, topics related to sex can be considered a taboo. Individuals in these settings do not give honest answers, making this item an unreliable indicator for depression (Haroz, et al., 2016). The item “thoughts of killing oneself/suicide” was not found to be a good indicator for depression in Thailand (Haroz, et al., 2016). “Recent findings have shown that while depression is a risk factor for suicide ideation in high-income countries, impulse control disorders are more strongly associated with thoughts of death and suicide in many LMIC” (Haroz, et al., 2016, p. 989).

Another interesting finding of the study was how different items were indicative of different levels of severity for depression in different settings. For example, in Indonesia, the item “low energy or fatigue” is an indication of mild depression, while in a different setting, the item might be correlated with severe depression (Haroz, et al., 2016). The study’s results also were descriptive for people with higher levels of depression rather than average levels (Haroz, et al., 2016), which could pose some limitations.

A different study focusing on the applicability of a widely used depression scale was conducted with Asian samples (Oei, Sawang, Goh, & Mukhtar, 2013). The DASS-21 is an instrument used to measure depression, anxiety, and stress, and it has been used with Hispanic Americans, British, and Australian adults with high levels of reliability and validity (Oei, Sawang, Goh, & Mukhtar, 2013). “Cross-cultural research has shown that Asians tend to have higher levels of collectivistic values which prioritize group goals over individual goals. These cultural values can also impact on how individuals express their emotions [...] the way an

individual talks about distress and how it is perceived and defined will be a function of his or her culture” (Oei, Sawang, Goh, & Mukhtar, 2013, par. 7).

The original DASS has 21 items. For the purpose of this study, three of those items: “I found it difficult to relax,” “I found myself getting agitated,” and “I felt that I was using a lot of nervous energy” (Oei, Sawang, Goh, & Mukhtar, 2013, par. 36) were removed from the factor “Stress”. The resulting DASS-18 presented high internal reliability with Asian samples from six different countries: Indonesia, Malaysia, Singapore, Sri Lanka, Taiwan and Thailand (Oei, Sawang, Goh, & Mukhtar, 2013). The problems with generalization across cultures are not simply concerns about the language translation of the item questions, rather they extend to concerns regarding how participants from a culture might perceive those items (Oei, Sawang, Goh, & Mukhtar, 2013). For instance, the reason behind removing the item “I found it difficult to relax”, was that participants in certain Asian countries, such as Singapore or Thailand, might perceive relaxing as lazy behavior, which is not in agreement with their cultural values (Oei, Sawang, Goh, & Mukhtar, 2013). This connects with a certain bias that cross-cultural researchers are especially concerned with, the “desirability bias” (Alarcón, 2009). Responses from these cultures might be influenced by the stigmas that depression, and related disorders such as anxiety might carry. The participant’s desire to not disagree with his/her culture values might prevail over his/her sense of help needed.

Differences in Depression Factors

Adolescents’ beliefs and attitudes about depression can fundamentally influence the symptom’s severity, the treatment plan and the adherence to recommendations (Dardas, Silva, Scott, Gondwe, Smoski, Noonan, & Simmons, 2018). A study conducted on Arab adolescents

found that the main three believed factors affecting depression, which can overlap, are stressful events (72%), social factors (65%), and weak will (56%) (Dardas, et al., 2018). The latter is an interesting reason to examine. The least believed factors Arab adolescents think affect depression are genetics (24%), chemical imbalance (30%), and punishment for wrong doings (35%) (Dardas, et al., 2018). The latter one once again is an interesting belief factor. Although it is one of the least believed factors, a third of the respondents marked it, which could have religious reasons, as well as “weak will” might. These beliefs also influence the type and severity of depression (Dardas, et al., 2018).

The differences in depression across cultures are also expressed in the kind of symptoms each culture experiences. It is known that guilt is more frequent in large areas of Africa and in Europe than it is in Eastern cultures (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001, p. 13). This is a consequence of the presence of Judeo-Christian societies in these areas of the world. There has been a decline in guilt over the last 100 years, which has been associated with the decline of religious presence in Western cultures. Islamic countries show frequent feelings of guilt as well (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001, p. 13). Guilt is overall more frequent in the Western world. In the Eastern and non-Christian cultures, depressed individuals deal more often with hypochondriac symptoms (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001, p. 13). A cross-cultural study conducted with participants from Austria and Pakistan exploring guilt found that depressed patients from Austria were more likely to present depressed mood, guilt, suicidal tendencies, problems with work and daily activities, and insomnia (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001). The patients of Pakistan, on the other hand, were more likely to present psychic and somatic anxiety,

hypochondriasis, loss of appetite, fatigue, depersonalization and paranoid symptoms (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001).

In this study, guilt was subdivided into several components. “Both feelings and delusions of guilt stem from the non-fulfilment of ethical challenges and are subject to biological, socio-cultural and situational influences” (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001, p. 13). Guilt can also be called “ethical feeling” and it emerges from an individual’s personal or cultural values being challenged (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001). In this situation, one’s conscience is activated and personal responsibility is taken. “Ethical feelings” arise when no action takes place. Guilt and shame act as “censors of conduct” (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001). For instance, in Pakistan, the main values are honor, dignity, pride, virility and family ties (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001). Actions that go in a different direction of these values trigger feelings of shame. The concepts of shame and guilt are often used interchangeably, but they are quite different. Guilt is usually an internal process, caused by feelings of responsibility or remorse; while shame is more public, and arises from acting dishonorably or improper. Cultures in which free will is predominant over determinism will take responsibility for events, and as a consequence experience guilt (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001).

The study’s findings call for an adaptation in the 21-item HRDS, the Hamilton Depression Rating Scale, a widely used instrument in transcultural studies (Stompe, Ortwein-Swoboda, Chaudhry, & Friedmann, 2001). The scale’s items only list “guilt” as an indicator for depression, but the previous study proves that “shame” can also be an indicator for depression in Eastern cultures.

Another factor that has been associated with depression is parenting processes and internalizing behaviors. A study focuses on parenting processes as a predictor for depressive and anxious systems across different cultural settings (Vazsonyi, & Belliston, 2006). “Studies have consistently documented that children and youth enjoy healthy development and positive adjustment when there exists sufficient closeness and warmth in the parent-child dyad together with sufficient parental autonomy granting” (Vazsonyi, & Belliston, 2006, p. 491). We know that too much parental control, conflict and inconsistent support is correlated with depressive symptoms. The study concluded that individual parenting and internalizing behaviors are highly similar across cultures (Vazsonyi, & Belliston, 2006). The two main predictors across cultures are parental support and conflict. There were two inconsistencies across cultures relating to different aspects of parenting processes. For American youth, parental approval seems to have a tight relationship with the developing of symptoms, as compared to Dutch youth (Vazsonyi, & Belliston, 2006). A possible explanation for this might be that American parents use mechanisms of control more frequently than Dutch parents. In America, maternal peer approval had also a larger effect on depression symptoms on youth, than it did for Dutch, Hungarian, and Swiss youth (Vazsonyi, & Belliston, 2006).

Gender

The differences in gender for depression are quite significant. Females usually present higher levels of depression, less help-seeking, and different symptoms. The overall DASS-21 score is higher for Chinese women than for men (Oei, Sawang, Goh, & Mukhtar, 2013). Research conducted in Nepal, Finland, Portugal, Germany, Poland and North America concluded that there is a 2-1 female-to-male ratio for depression, meaning there are twice as many women

as there are men that experience depression across the globe, and the ratio is stable across cultures (Loers, 2010).

Girls have also been found to cope with stressful factors differently than boys, affecting their experience of depression. A study examining coping strategies across cultures and across genders, with Chinese and Canadian participants, found that girls are more likely to experience higher levels of depression, and that those gender differences might emerge from vulnerability difference levels. Girls are also more likely to react to stressors with a ruminative style, which means they repetitively think about the stressor, a style that perdures into adulthood.

There is a common theme of women “self-silencing” when it comes to health, particularly cancer, HIV, eating disorders, heart disease, premenstrual syndrome, post-partum depression and abusive relationships (Loers, 2010). Below is an account of one of the most unknown and unexplored disorders.

Post-Partum Depression

An extremely prevalent, yet overlooked type of depression, that affects somewhere between 10-20% of mothers worldwide is Post-Partum Depression (PPD) (Evagorou, Arvaniti, Samakouri, 2016). The disorder is characterized by similar symptoms of a depressive episode with the addition of irrational fears for their child and concerns about the child’s health, and suicide (Evagorou, Arvaniti, Samakouri, 2016). The disorder can show up between the first and 12th month of the postpartum period (Evagorou, Arvaniti, Samakouri, 2016). It is a severe disorder that 80% of the time goes undiagnosed and untreated, causing long-term negative effects for both the child and the mother, as well as the family’s harmony (Evagorou, Arvaniti,

Samakouri, 2016). The depression puts the maternal duties in danger, and increases the risk for suicide and child neglecting.

The causes for this have not been pinpointed, but it is known that there are predisposing factors that increase the risk for its appearance. These include history of depression in the family, low-income, low social support, low self-esteem and unwanted or unplanned pregnancies (Evagorou, Arvaniti, Samakouri, 2016). The beliefs held in different societies influence the emotional experiences of the mother as well as the expression of her symptoms. The expression clearly differs between Western and non-Western countries (Evagorou, Arvaniti, Samakouri, 2016).

PPD in Asia.

The emotional disturbances women experience in these countries are usually expressed through physical symptoms. The postnatal practices in these countries focus on the mother, and on bringing her back to her pre-pregnancy “normal” stage. There are higher levels of symptoms experienced by Asian women than in Western countries. In China, women have reported experiencing fevers, muscle pain, chills, low energy, and exhaustion (Evagorou, Arvaniti, Samakouri, 2016). In Hong Kong, the symptoms include fatigue, confusion, loss of control, frustration, sadness, stress, panic, fear and feelings of hopelessness (Evagorou, Arvaniti, Samakouri, 2016). In Israel, the women experience depression through hypochondriac behaviors. In Iran, women manifest the symptoms through constant feelings of guilt (Evagorou, Arvaniti, Samakouri, 2016). The prevalence in these countries varies from 0.5-6.8% in Singapore to numbers as high as 33% in Vietnam and 32.4% in India (Evagorou, Arvaniti, Samakouri, 2016).

PPD in Africa.

“PPD is characterized primarily by physical symptoms, because of the fear of social stigmatization of women” (Evagorou, Arvaniti, Samakouri, 2016, p. 135). Some of the symptoms include nausea, headaches, increased irritability, and general body pain (Evagorou, Arvaniti, Samakouri, 2016). African cultures are ethnokinship cultures, which share the physical symptoms of Asian cultures and have a focus on the mother during the post-natal period (Evagorou, Arvaniti, Samakouri, 2016). The following cultures in Europe, Australia and North America are technocentric, with a primary focus both on the mother and the baby (Evagorou, Arvaniti, Samakouri, 2016).

PPD in Europe.

Depression in European countries manifest with the typical depressive symptoms, and their post-natal support comes from machines and health professionals, as opposed to family and community support experienced by ethnokinship cultures, that include the countries discussed above (Evagorou, Arvaniti, Samakouri, 2016). For instance, in France and the U.K., women experience a strong sense of guilt, stress, anxiety, panic and fear, with no clear triggering causes for the symptoms. The prevalence in Europe ranges from 2.87-13% in Italy to 5-22% in the U.K (Evagorou, Arvaniti, Samakouri, 2016).

PPD in Australia.

The symptoms experienced in these settings again resemble those of a depressive episode. The symptoms here include: sadness, guiltiness, suicidal thoughts, loss of control, loss of interest in simple daily activities and feelings of loneliness and isolation (Evagorou, Arvaniti, Samakouri, 2016). “Women with PPD report significant frustration because of the gap between

their expectations of motherhood and the reality due to their illness, with problems in adapting to (the) maternal role” (Evagorou, Arvaniti, Samakouri, 2016, p. 138).

PPD in North America.

Post-Partum Depression is manifested through psychological symptoms. Canada has one of the lowest prevalence rates, 4.5-8.68% (Evagorou, Arvaniti, Samakouri, 2016). This might be due to the post-natal support system that Canadian women are offered, through their hospital or through different mental institutions, or the stigma associated with this disorder. Mothers feel inadequate and guilty, and are embarrassed to admit to how they are feeling, so their natural response is to normalize their symptoms and to not seek out for help, out of fear of being called “bad mothers” (Evagorou, Arvaniti, Samakouri, 2016).

PPD in South America.

Literature on the topic reveals that the rates of PPD in South American countries are at its highest, with the highest prevalence rate recorded being 57% in Colombia, followed by 42.8% in Brazil, 57% in Guyana and 4.6-48% in Chile (Evagorou, Arvaniti, Samakouri, 2016). In Brazil, most women’s symptoms are identified through her family members, who observe a drastic change in the mother’s behavior (Evagorou, Arvaniti, Samakouri, 2016). This disorder can be extremely dangerous if not treated quickly and appropriately, since it can have lasting effects on both the mother and the child, who might never establish a bond. The mothers feel regret and refuse to take care of the baby, not accepting their new role as a mother.

PPD conclusion.

The study combines data obtained from 106 articles relating to PPD, and the findings concluded that all the different cultures presented the same risk factors for developing the

disorder. These might be predisposing factors such as low income, unwanted or unplanned pregnancies, premature birth, poor conditions of living, unemployment, stressful life events, or poor family and marital relationships (Evagorou, Arvaniti, Samakouri, 2016). There are other cultural factors that affect the appearance of the disorder in new-mothers. Cultures in which there is an overt preference for males, and in which there exists gender discrimination can influence the development of the disorder, especially if the baby born is a female (Evagorou, Arvaniti, Samakouri, 2016). Another factor is the cultural post-natal practices that are aimed to help women transition. It has been found that many times, these practices can have the contrary effect and contribute to the detrimental symptoms women experience. Countries such as Japan, Hong Kong, Taiwan, Nigeria and Uganda provide such practices (Evagorou, Arvaniti, Samakouri, 2016).

The study also observed that the prevalence rates in non-Western countries is usually more varied across countries, and higher in general (although not higher in reporting) (Evagorou, Arvaniti, Samakouri, 2016). The study also identified that the more non-Western a culture is, the more somatization occurs. The symptoms experienced by women in these countries are manifested mainly through physical symptoms, “because of the different perceptions of mental health, the negative attitude towards its disorders, and the high expectations of some cultures for motherhood” (Evagorou, Arvaniti, Samakouri, 2016, p. 144). Women must normalize the symptoms (e.g.: India), or repress them without complaint (e.g.: Jordan) (Evagorou, Arvaniti, Samakouri, 2016).

China vs North America

A cross-cultural study with Canadian and Chinese participants found that the use of maladaptive coping strategies is associated with higher levels of depression for both Chinese and Canadian adolescents (Auerbach, Abela, Zhu, & Yao, 2010). The differences between these two countries are the kind of stressors that the students felt. For Canadians, who are part of the Western culture, their main stressors were conflict at home with parents or with peers; while Chinese students described academic and cultural factors to be their source of stress (Auerbach, Abela, Zhu, & Yao, 2010). “Escalating social pressures are being placed on Chinese youth to excel in school, resulting in increased stress and decreased leisure time” (Auerbach, Abela, Zhu, & Yao, 2010, p. 559). Furthermore, the modernization and Westernization that China is currently undergoing has breached with the traditional values that once dictated the lifestyle in the country and its citizen’s expectations (Auerbach, Abela, Zhu, & Yao, 2010). The old and the new generations clash in their approach to their lifestyle, and that can be seen with the kind of social support and coping strategies that Chinese individuals turn to. Historically, China has been a collectivist culture in which its members turn to the community for support and coping; nowadays, younger Chinese individuals are turning towards more individualistic strategies and values (Auerbach, Abela, Zhu, & Yao, 2010).

The stigma about mental illnesses is one of the main factors why depressive symptoms vary across cultures, and why depression goes untreated in many different settings. It prevents people suffering from it to be diagnosed and provided with treatment. It is well known that the stigma is even bigger in Asian countries as compared to Western countries, especially Canada and America. A study done with Chinese Americans and Caucasian Americans found that

Chinese Americans had a higher rating for stigma of disorders, especially major depression and psychotic depression (Hsu, Wan, Chang, Summergrad, Tsang, & Chen, 2008). The stigma is believed to arise from fear, shame, social values and sanctions (Hsu, et al., 2008). It is also psychotic symptoms that are more stigmatized than physical symptoms (Hsu, et al., 2008), perhaps providing an insight into why Asian cultures manifest physical symptoms for depression more frequently than psychological symptoms. “The stigma of mental illness causes mentally ill patients to be discriminated against and ostracized, leading to poor self-esteem, persistent depression, social isolation, unemployment, and low social status. This stigma acts as a major obstacle to the detection and treatment of mental disorders, and it is prevalent in all cultures” (Hsu, et al., 2008, par. 3).

Asian and Hispanic populations, compared to Caucasian individuals, believe that mentally ill individuals are more dangerous (Hsu, et al., 2008). The study also found that somatoform depression was less stigmatized than other kinds of depression, explaining why depressed Chinese American (and Chinese) patients present higher levels of somatic symptoms (Hsu, et al., 2008).

Conclusion

This research paper has provided with different accounts as to why cultural factors are an essential aspect of depression, whether these are attitudes and beliefs, stigmatization, or parenting styles. These aspects essentially affect how an individual from a certain culture will first experience depression (physical vs psychological symptoms), how they will express it (seeking out for help vs repressing it), and how this affects the estimated prevalence of depression across cultures. The prevalence provided for different countries has been gathered

from multiple cross-cultural studies. The limitation of whether the assessments utilized are culturally appropriate and generalizable, and whether cultural values such as stigma act as obstacles to clearly establishing a percentage of individuals experiencing depression (as it is defined by the DSM-V), remain. The path to a more culturally sensitive and inclusive diagnosis, not just of depression, but of any clinical disorder, has been supported by extensive research and professionals in the field. There is no question that the way an individual perceives, feels, and expresses depression varies across cultures, as the research paper has sustained. Nevertheless, an update in the criterion for diagnosis needs to be made in order to be able to study depression in a valid and reliable manner.

There have been justifications and extensive research evidence that supports the inclusion of cultural factors in psychiatric diagnosis (Alarcón, 2009). The implementation of what has come to be known as “cultural psychiatry”, is not a specific approach or a psychiatry for minority groups (Alarcón, 2009). It is an essential perspective and group of factors that need to be taken into consideration within the first phase of any clinical evaluation. Cultural psychiatry applies to all psychiatric conditions (Alarcón, 2009), not just “culture-bound syndromes”, which are clinical diagnosis related to a specific area or culture. These syndromes were first included in the DSM-III (Alarcón, 2009). The description of the syndromes are often too similar or too vague to be categorized (Alarcón, 2009), which leads to some criticisms regarding the DSM-V, the latest update in the manual. The main criticism in terms of culture, is that the manual is ethnocentric (Alarcón, 2009) in that it is white-centered since it is an American manual and its content is based on research predominantly done in the U.S. and with people of the same

ethnicity. The critics claim that fundamental factors such as age, culture and gender are most often ignored (Alarcón, 2009).

A step towards a cultural psychiatry is to learn to identify what is cultural in the clinical area, or what creates a specific “environment” (Alarcón, 2009). Some of the main aspects that need to be covered for a well-structured clinical interview include cultural variables, family data, and pathogenic and pathoplastic factors, amongst others. The cultural variables include but are not limited to language, religion or spirituality (dictating values and attitudes held by individuals), gender and sexual orientation, tradition and belief (tightly linked to ethnicity and the patient’s sense of individual and group identity), and finally migration history and level of acculturation (Alarcón, 2009). The family data (paternal processes and internalizing behavior) constitutes a culture, or “micro-culture/environment” in itself. The roles, the hierarchies, the kind of social interactions, activities which provide with values and roles, and perhaps most importantly the help-seeking patterns that the family in question fosters, all reveal crucial information about the participant’s narrative and his/her view of the world; and thus, how a disorder might be experienced and expressed to the outside world (Alarcón, 2009).

The pathogenic and pathoplastic factors encompass a “macro-environment”. Pathogenic factors recognize whether the source is benign and therefore preventable, or harmful (Alarcón, 2009). Some factors include family life, media, socio-political environment, schooling norms or church affiliation (Alarcón, 2009). Pathoplastic refers to the symptoms expression (physical vs psychological symptoms). “Environment shapes the form (not only the substance) of the symptoms [...] The distinction between the appearance of the symptom, its verbal description,

and the patient's surrounding reality continues to be the key element of this part (initial phase) of the evaluation" (Alarcón, 2009, par. 34)

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