

Culture and depression

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Abstract

To treat depression effectively, members of the multi-disciplinary mental health team must adopt a holistic approach that incorporates the biopsychosocial model of disease. Other factors such as religiosity, spirituality and culture must also be taken into consideration when eliciting a psychiatric history from a patient experiencing depressive illness. This review article focuses on the cultural factors of depressive illness and how these can influence disease detection, progression, treatment and outcome.

Keywords: depression, culture, idioms of distress, cultural literacy

Introduction

Unlike humans, depression does not discriminate. Indeed, a broad and diverse population of people, regardless of their age, ethnicity, socioeconomic status, cultural background or nationality can succumb to depressive illness and the number of people afflicted with this disease continues to rise. Worldwide, more than 300 million people experience depression (1) and, according to the Global Burden of Disease Study, this type of mood disorder is projected to be the leading cause of disability by 2020 (2). Depressive illness, therefore, concerns us all, from the melancholic mother in a rural setting in Lesotho presenting to her family doctor following the birth of her stillborn child, to the consultant psychiatrist working in a community adult mental health team in South London prescribing antidepressants to a young 'migrant man' who was torn apart from his family in war-torn Damascus, Syria.

To treat depression effectively, members of the multi-disciplinary mental health team must adopt a holistic approach that incorporates the biopsychosocial model of disease. Other factors such as religiosity, spirituality and culture must also be taken into consideration when eliciting a psychiatric history from a patient experiencing depressive illness. Interestingly, these factors can either render a patient at risk of developing depression or confer protection upon them, depending on the context. For example, a 'culture of shame' can act as a barrier to accessing and using mental health services for a young Bengali lady in Leicester who is experiencing low mood and anhedonia which can, consequently, deprive her of the benefits of early intervention making her more vulnerable to developing a more severe depressive illness with co-existent suicidal ideation. However, that very same culture also promotes community cohesion, and the resultant social inclusion can protect and prevent individuals from becoming depressed; it can enable and empower them to be resilient in the face of adversity.

Culture has been defined as the "learned, shared and transmitted values, beliefs, norms and life ways of a particular group [of people] that guides their thinking, decision-making, and actions in patterned [stereotypical] ways" (3). The term depression cannot be translated into many of the world's languages. This is not to say that depression as a disease does not exist in certain cultural groups. Rather, a hypothesis that has been postulated regarding the 'idioms of distress' that an individual conveys and expresses during bouts of emotional and/or behavioural disturbances reflects the explanatory models that are formulated by the cultural group that he or she belongs to (4). For example, an older first-generation Muslim man may eventually present to his GP with the biological symptoms of depression reporting chest pain and difficulty in breathing. Recognising this, the GP shrewdly makes a referral to specialist psychiatric services (after excluding organic causes of this patient's symptoms). The mental health professional is expected to have the cultural literacy to understand why this older Muslim patient may attribute his somatic symptoms to supernatural causes such as jinn possession and/or 'the evil eye'. The mental health professional

is also expected to appreciate why his or her patient may have consulted a Muslim faith healer or 'raqi', self-proclaimed or otherwise, for 'exorcism' as opposed to seeking medical management. It is important for mental health professionals to understand that such beliefs are not delusional since they are consistent with the cultural norms of the patient (5).

In view of the above, we conducted a review of the literature to identify studies that focus on the cultural factors of depressive illness and how this can influence disease detection, progression, treatment and outcome.

Methodology

From 2 - 11 May 2014 we searched for articles that were listed in PubMed that were relevant to research conducted on depression and culture. The following MeSH terms were used with respective search results in brackets: depression (n = 11333), culture (n = 5653), depression AND culture (n = 299), depression AND culture AND services (n = 64) and depression AND culture AND services AND mood (n = 11).

Filters were adjusted on PubMed to identify specific research papers (clinical trials) that were relevant to the aim of our review. These were 'clinical trial', 'full text', 'past 10 years', 'human trials' and 'English language'. These filters were selected so that the full texts of the studies could be easily accessible. After reading the abstracts of the papers that were identified, we selected three trials that met the inclusion criteria of our review. The inclusion criteria for selected papers included a diagnosis of depression in patients at the time of the trial, description of the ethnic background of participants recruited and a sample size of greater than 300 patients. Below, we will discuss and describe the salient findings of each trial.

Paper 1 - Ethnic inequalities in the use of secondary and tertiary mental health services among patients with obsessive-compulsive disorder

This trial was comprised of 35,000 patients receiving treatment for either obsessive compulsive disorder (OCD) or depression from South London and the Maudsley (SLaM) mental health services in the United Kingdom. Participants recruited for the trial for which there was no ethnic background recorded were excluded from analyses. Based on this criterion, 1,528 individuals with OCD and 22,716 individuals with depression were included (6).

The results of this study revealed that individuals from black and ethnic minority (BEM) backgrounds were significantly underrepresented in this clinical population. This was the same throughout secondary and tertiary services. These findings are at odds with the fact that OCD is at least as prevalent in individuals from BME backgrounds as it is in Caucasian individuals in the general population (6).

There were significant inequalities in patients from BEM backgrounds with OCD compared with those from the same background with depression. Possible explanations for these inequalities include lower levels of help-seeking in individuals with OCD compared to those with depression, higher levels of stigma and shame attached to OCD compared to depression in individuals from BME backgrounds, ritualistic behaviour possibly being subsumed under religious rituals and the use of other resources such as family members (6).

Paper 2 - Does minority racial-ethnic status moderate outcomes of collaborative care for depression?

In this randomised controlled trial (RCT), 18,306 patients were screened by phone using the nine-item depression scale of the Patient Health Questionnaire (PHQ-9). A total of 1,260 (7%) individuals screened positive for depression as defined by a PHQ-9 score ≥ 12 (7).

A total of 471 of those who screened positive for depression met the inclusion criteria for the study and 430 agreed to participate. 395 participants (92%) attended the appointment and provided written consent. Patients were randomized to treatment as usual (n=218) and to collaborative care (n=177). Follow-up telephone interviews were completed for 360 (91%) of the study participants at six months (7).

Patients assigned randomly to the intervention group received a stepped-care model of depression treatment for up to 12 months. Of the 360 patients, 272 (75%) were Caucasian and 88 (25%) were from a

minority group, including 64 (18%) African Americans, 11 (3%) Native Americans and 13 (3.6%) individuals from other ethnic groups. The authors found that minority group status remained a significant moderator of the intervention's effect on treatment response ($OR=6.02$, $p\leq.01$) (7).

The results supported the authors' hypothesis that the minority group would respond better than Caucasians to the collaborative care intervention. The findings indicated that patients from ethnic minority backgrounds with depression can be successfully treated in a primary care setting that implements a collaborative care program. This RCT lends support for the use of these programs in an array of populations and health care systems (7).

Paper 3 - Effects of race and ethnicity on depression treatment outcomes: the CO-MED trial

CO-MED was a seven-month single-blind RCT that compared the efficacy of combination antidepressant medication to that of a selective serotonin reuptake inhibitor (SSRI), escitalopram, plus a placebo. Outpatients with nonpsychotic major depressive disorder (MDD) were recruited from six primary and nine psychiatric care sites. A sample size of 660 outpatients was chosen to allow detection of an approximately 15% difference in remission rate between each antidepressant combination and escitalopram plus placebo (with an expected remission rate of 35%) (8).

Broad inclusion and minimal exclusion criteria to recruit participants were used to ensure a reasonably representative sample and were as follows: outpatient enrollees, 18–75 years of age, and a DSM-IV diagnosis of either recurrent or chronic MDD (8).

A 12-week study period was used so that maximal doses of medications could be administered for at least four weeks and allowing enough time for remission in patients with depressive illness to be detected. 665 (91%) were randomly assigned to a treatment group, the breakdown of which is as follows: 352 non-Hispanic whites (59%), 169 blacks (28%), and 79 white Hispanics (13%). Whites had the earliest age of first major depressive episode (mean age=22.8), which was significantly earlier than for blacks (mean age=26.5, $p<.01$). Compared with whites (50%), a significantly greater percentage of blacks (61%, $p=.01$) had chronic depression; there was no difference between blacks and Hispanics (60%) (8).

After adjustment for baseline sociodemographic background and comorbidity, outcomes for participants receiving single or combination antidepressant treatment were similar for white, black, and Hispanic participants. This study showed that disparities in outcome among participants from different racial-ethnic groups can be minimized with measurement-based care (8).

Discussion

The aim of this review was to investigate the ways in which psychiatric services approach depression in patients from ethnic minority backgrounds. The three trials included in the review varied in sample size and participants were recruited from primary, secondary and tertiary mental health settings.

The first trial showed that patients from ethnic minority backgrounds were significantly underrepresented in secondary and tertiary mental health services. The minority groups in the second trial responded better to a collaborative care approach compared to treatment as usual in primary care settings. The third trial showed that there were differences between ethnicity in the intensity of the depressive symptoms and that both blacks and Hispanics demonstrated higher rates of depression compared to whites.

Recent research suggests that patients with depression from ethnic minority backgrounds show poor adherence with psychotropic medication and that they were more amenable to receiving psychosocial support (9).

Conclusion

Depression can affect anyone, regardless of their cultural background, and is a leading cause of disability worldwide. Many people from ethnic minority backgrounds who experience depressive illness continue to suffer in silence despite the availability of effective treatment. Future research that explores the barriers to accessing and receiving care in this group is urgently needed. Indeed, influence of culture in varied presentations of depression, often leading to barriers to access effective treatment, cannot be ignored.

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