

**The investigation of Depression health mental between variousethnic cultures: Brief Review**Reza Ahmadi<sup>1</sup>, Mohammad Khan ahmadi<sup>2</sup>, Maryam Malmir<sup>3</sup>, Azita Amin al-roaya<sup>4</sup><sup>1</sup>: MA in Exceptional Children, AllamehTabatabaei University, Iran<sup>2</sup>: MA in Psychology, AllamehTabatabaei University, Iran<sup>3</sup>: PhD Student of Exceptional Children, Islamic Azad University, Iran<sup>4</sup>: PhD Student of Exceptional Children, Islamic Azad University, Iran[khanahmadimohammad14@yahoo.com](mailto:khanahmadimohammad14@yahoo.com)

**Abstract:** Depression is under-diagnosed in primary care all over the world, particularly in ethnic minority populations. Several explanations have been offered for this including the unsatisfactory 'Western' definitions of depression, different explanatory models between patient and doctor, linguistic barriers and variations in presentation. Such problems may also exist in secondary health of mental care services. Help-seeking behavior remains a problem in the management of depression in ethnic minority populations, partly due to stigma associated with mental illness (although this may be changing due to acculturation), and differing illness beliefs. Depression may present with somatic symptoms and cultural idioms of distress in any culture, particularly ethnic minority levels. The common presentation of depression as somatic symptoms in patients from certain cultures may be explained by the traditional illness beliefs within those cultures. The use of trained interpreters, raising awareness of depression and a culturally sensitive approach to clinical practice amongst other strategies may help us diagnose depression and improve help seeking-behavior.

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**Key words:** depression, health seeking behavior, minority levels, somatic presentation, idioms of distress

**1. Introduction**

From the perspective of cultural psychiatry, culture influences the sources, the symptoms and the idioms of distress; the individuals' explanatory models, their coping mechanisms and their help-seeking behavior; as well as the social response to distress and to disability (Kirmayer, 2001). Culture is reflected in the learned, shared beliefs, values, attitudes and behaviors characteristic of a society or population (Bhugra & Mastrogianni, 2009). This is of particular interest to clinicians in light of the World Health Organization's prediction that by the year 2020, depression will be the second most important cause of disability after ischemic heart disease worldwide (WHO, 2009). In this paper, we review the literature on depression in ethnic minority levels and examine the difficulties doctors face in terms of diagnosing this condition. The problem of depression crosses cultural, international and socioeconomic boundaries, and is one of the great challenges of health of mental care today. Asian Americans have been shown to have a lower prevalence of depression (Jackson-Triche et al., 2011) than majority white populations. Several studies from the USA show that rates of depression are similar among African Americans and White Americans when demographic, sociocultural and socio-economic factors were controlled for (Roberts et al., 1981; Somervell et al., 1989; Diala et al., 2001). Some studies have found

Hispanic populations to have a higher rate of depressive symptoms than the majority population (Roberts, 1981), particularly Puerto Ricans (Oquendo et al., 2001). This difference could be explained by genetic or vulnerability factors, or by exposure to different social or environmental experiences (Kendler et al., 1992; Finlay-Jones & Brown, 1981). In the UK, Shaw et al. (1999) comparing African-Caribbean and White European levels in Manchester found that the prevalence of depression was higher in the former, especially women.

Stansfeld et al. (2009) found that non-UK White girls (mostly of Irish, Greek or Turkish origin) had a higher risk of depressive symptoms relative to White UK pupils. Bhui et al. (2001), in a survey in London of general practice attenders, reported that Punjabis were not rated as having more depression than the English participants, yet they did have more depressive ideas. However, Bangladeshi pupils were at decreased risk of psychological distress relative to White UK pupils possibly due to ethnically related protective factors (Costello et al., 1997) such as high levels of family support, religious belief, strong cultural identity and cohesion. This increased risk was diminished after adjustment for recent migration, suggesting that it might relate to stressors associated with migration.

Recent migration can cause psychological distress as a result of traumatic experiences prior to

migration, separation from parents and friends, and difficulties adjusting to a new, alien environment (Bhugra, 2001). Several explanations have been proposed for these variations in depression rates. On the other hand, certain cultures have family-oriented cultural values, which could be patho-protective. For example, socioeconomic adversity and interpersonal and family problems were found to be major risk factors for depressive disorders in Pakistan, whereas supportive family and friends may protect against development of these disorders (Mirza & Jenkins, 2009).

Ballenger et al. (2001) suggest that variations in prevalence rates across ethnic levels may be consequences of methodological issues and a lack of culturally appropriate instruments. This debate reflects on the use of either etic or emic instruments for the recognition and evaluation of health of mental disorders. Hence researchers now attempt to combine quantitative research with a more flexible approach (Weiss et al., 1992; Lloyd et al., 1996). Similar trends have been seen in south-Asian communities in England (Bhugra et al., 1999). Bhui suggests that epidemiologists need to learn more about qualitative data analysis, its use with quantitative data and the limitations of each approach. Furthermore, gathering accurate data on the prevalence of depression in ethnic minority populations has proved difficult. Studies have shown that the risk of major depression seems to be greater for US-born Mexican Americans than for Mexican immigrants (Burnam et al., 1987) and the lifetime rate in US-born Cuban Americans was significantly higher than for Cuban Americans born in Cuba (Narrow et al., 1990). Health of mental problems may be denied for several reasons e.g. it was found that Canadian migrants did so to improve their chances of employment (Sartorius & Schulze, 2005).

These figures could also be interpreted to mean that a greater degree of acculturation predisposes to depression, but the high levels of depressive symptoms among Puerto Ricans living in both Puerto Rico (29.1%) and New York City (28.6%) cautions against over-generalization. The effects of acculturation add another dimension to the influence of cultural factors on the development of mental illnesses including depression. Possible explanations include that immigrants experience a lower sense of deprivation, retain a stronger family orientation or other protective cultural values or that immigration tends to select for health of mental (Lewis-Fernandez et al, 2005a).

## 2. Material and Methods

DSM-IV suggests a cultural formulation as a supplement to the multiracial assessment (American Psychiatric Association, 1994), it has been argued that

it still represents Western concepts of illness and might not be easily applicable to other cultures (Ballenger et al., 2001; Kirkmayer, 2001). In addition, most authors agree that the 'Western' classifications of depression are not entirely satisfactory for use in non-Western cultures. The term 'depression' itself is absent from the languages of many cultures (Manson, 1995); it is used rarely in others (Hamdi et al., 1997), or it is construed differently.

Similar problems arise in secondary services providing health of mental care. In the UK, one study found that the knowledge of health of mental staff was constructed upon stereotypes of eastern cultures as repressive, patriarchal and inferior to a western cultural ideal. These ethnocentric attitudes have the potential to misdirect diagnosis and therefore, treatment pathways (Burr, 2009).

The use of trained medical interpreters can result in a higher quality of physician-patient interaction. To improve recognition of depression and poor help-seeking behavior in ethnic minority populations, several measures can be taken by health care providers.

Following examination of the articles and reports selected for full review, a number of clear topic areas emerged. The use of family, friends, children, untrained language-speaking staff, non-clinical staff, and persons from the waiting area should be avoided. This enabled the literature to be ordered into 15 levelings or 'chapters'. These included seven 'clinical' areas which were ordered in a similar sequence to that used in the international disease classification (ICD-10). In addition, there were seven levelings or 'chapters' which were best described as 'service' areas. These included primary care; interpretation, language and translation services; and health improvement/promotion. A final level consisted of papers which related to general access issues rather than a specific disease or service area.

An important consideration in depression in ethnic minority patients is presentation with somatic symptoms. Early studies suggested that somatization of depressive symptoms was mostly seen in non-Western cultures. However, several studies since have shown that somatic presentations of depression are frequent across different cultural and ethnic levels (Kleinman, 1995; Kirkmayer & Young, 1998). However, in the USA, somatic presentation may be particularly common among Hispanic sublevels, which have been found to present psychological distress in the form of physical symptoms (Mezzich & Raab, 1980; Canino et al., 1987; Canino et al., 1992). In one study, Mexican American women were found to be more likely to report somatic symptoms of depression than white women (Escobar et al, 1987). In addition, it has been reported that Punjabi patients

visiting their general practitioner more often had depressive ideas, but were no more likely to have somatic symptoms than English patients (Bhui, 2001).

Culturally patterned idioms of distress (Guarnaccia, 2003; Lewis-Fernandez et al., 2005b) are linguistic and bodily styles of expressing and experiencing illness (Nichter, 1981) i.e. cultural ways of talking about distress. In the case of depression, these often take the form of somatic metaphors. For example, clinicians aware that some depressed Latinos may express acute fits of emotionality known as *ataques de nervios* (attacks of nerves) in response to interpersonal stressors can more easily prevent their misdiagnosis as syncope, octal, or panic episodes (Lewis-Fernandez et al., 2005b). Knowledge of these cultural idioms can facilitate diagnosis of depression, establish rapport, and minimize the risk of misdiagnosis.

### 3. Results

These fell into two main categories: those assessing the scale of the problem i.e. patterns of disease and risk in minority ethnic levels (3 papers) and those examining access issues (3 papers). The review identified a total of 25 articles in this area, all in the peer-reviewed literature. Only six papers were rated 'A'. The former articles are based on mortality data, although this may be potentially misleading because it usually uses birthplace information from death certificates. Furthermore, there is a strong need for improved information on morbidity, which at present is based on incomplete ethnic monitoring data for inpatient episodes. Interventions are often discussed in terms of the need for 'lifestyle' changes and reducing risk. There is also some evidence that South Asian people may experience greater delays in accessing specialist management of heart disease, although this area remains contentious. These are linked to health promotion (preventive or educational) activities, rather than to improved or more appropriate services. It has been suggested that somatization is a concept that reflects the dualism inherent in Western biomedical practice, whereas in most traditional medical systems a sharp distinction between the 'mental' and the 'physical' does not occur (Kirmayer & Young, 1998). Once again (like diabetes), the literature principally focuses on Asian populations with little literature on African-Caribbeans. Similarly, the emphasis clinically is on heart disease, with little emphasis on stroke (cerebrovascular disease). For example, Chinese people have lower rates of depression and tend to deny depression or express it somatically. Pang (1998), exploring ways in which elderly Korean immigrants in the USA express depression, concluded that they also express emotions symbolically or physically. This is in accordance with

Korean traditional medicine, which allots symbolic functions to each body organ: the lungs are related to worry, sorrow and low spirit; the liver to anger; the kidneys to fear (Bhugra & Mastrogianni 2009).

The ancient Indian 'Ayurvedic' system also takes a more combined physical and mental approach. Symptoms of 'gas' and 'feelings of heat' were identified by Punjabi women in London (Bhugra et al, 1997a) which is in accordance with traditional ayurvedic models of hot and cold. Arab populations are also more likely than Westerners to associate depression with aches, pains and weakness, and use a variety of somatic metaphors to describe depression (Hamdi et al., 1997; Sulaiman et al., 2001). This correlates well with traditional Islamic or 'Prophetic medicine' which incorporated ideas assimilated from Hellenistic society (Arafa, 2011).

It has been noted that as acculturation proceeds, Asian immigrants tend to experience more effective and less somatic symptoms of depression possibly due to changes in the focus of self-attention (from somatic to affective) with increased acculturation (Chen et al., 2003). An alternative theory is that some patients may emphasize somatic symptoms to negotiate a biomedical system and thus may actually be trying to "speak the language" of the biomedical practitioner (Lewis-Fernandez, 2005b).

Awareness of the possibility of somatic presentations, and enquiring about the patients' understanding of the somatic symptoms. Clarifying the patients' use of specific cultural idioms of distress to describe the somatisation process and being familiar with somatic metaphors. Recognition that somatic symptoms are real and not imagined. Exploring physical symptoms in the context of stressors with open-ended questions such as: "What are the problems that you are facing now that create difficulty or distress?" Discussing the patient's physical distress in relationship to their life situation and stressors should be discussed. Many patients will find a biopsychosocial interpretation helpful. Rare possibilities should be considered e.g. Somatosensory amplification; patients are hypervigilant to irrelevant bodily stimuli and report their awareness of bodily sensations as physical distress and Alexithymia; an extreme inability to verbalize feelings or emotional states, such patients are likely to express emotions purely or primarily with physical symptoms.

### 4. Discussions

Psychiatrists will have to become more sensitive to multiple belongings, multi-ethnic communities, long-distance networks and flexible identities (Bibeau, 1997). The key to successful treatment of depression in this multicultural setting is further research into the experience and management of depression across

cultures, increasing awareness of cultural differences amongst clinicians, training in culturally sensitivity and novel strategies that help overcome these cultural boundaries. The cultural difficulties in the diagnosis of depression in ethnic minority populations, including explanatory models have been described and some of the practices and skills that psychiatrists and general practitioners can employ to overcome these have been identified. The process of globalization and continuing migration mean that the cultural boundaries that we have to negotiate in the management of diseases such as depression will change.

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