Medicine and Society

The cultures of depression

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ABSTRACT
Diverse frameworks, models and ‘cultures’ of depression have been postulated and promoted by psychiatrists, the pharmaceutical industry, general practitioners, primary care psychiatrists and the general population. Psychiatrists and the pharmaceutical industry endorse the medical model while general practitioners and the public subscribe to social and psychological frameworks. These models are partial truths and should be viewed as complementary rather than competitive, some more valid in a specific context than others. The issues that need to be resolved include: (i) re-examination of the validity of the psychiatric diagnosis of depression in the primary care context; (ii) a review of the adequacy of a single label of depression to describe the diverse human context of distress; (iii) acknowledging the problems of using a symptom checklist in diagnosing depression; (iv) recognizing the need for psychosocial diagnostic formulations; (v) explicitly stating the context, personality factors, acute and chronic stress and coping; (vi) highlighting the fact that antidepressant medication should be reserved for severe forms of distress; (vii) emphasizing the need to manage stress and alter coping strategies in the treatment of people with such presentations; (viii) focusing on other underlying causes of human misery including poverty, unmet needs and lack of rights. Clinically, there is a need to look beyond symptoms and explore personality, life events, situational difficulties and coping strategies in order to comprehensively evaluate the role of vulnerability, personality factors and stress in the causation of depression.


INTRODUCTION
The debate over depression has intensified over the past few decades. Diverse models of depression have been proposed. These divergent frameworks have resulted in a clash of the ‘cultures’ of depression. Historically, depression has become a battlefield where individuals, the general public, professional groups and governments propose and defend diverse and contradictory belief systems. Physicians, psychiatrists and academics working in primary and tertiary settings, and the pharmaceutical industry each have their own perspectives on the subject. I highlight the issues and suggest possible solutions.

CULTURE AND ITS TRANSMISSION
Culture is defined as the totality of knowledge, attitudes and habitual behaviour patterns shared and transmitted by members of a group or society. Members of a group are affiliated with each other, share history, language, background and characteristics that make them identifiable within their own group. This traditional definition and the components of culture, often employed to describe diverse societies, are equally applicable to the context of depression and its diverse proponents and users.

THE PSYCHIATRIC CULTURE
Diverse theoretical models have been employed to conceptualize psychiatric disorders. However, the medical model has increased its hold on psychiatric thought over the past few decades. It views psychiatric disorders as diseases, supposes a central nervous system aetiology and pathogenesis, documents signs and symptoms, offers differential diagnoses, recommends somatic therapies and prognosticates about the course and outcome. The identification of possible neurotransmitter mechanisms and the response to specific pharmacological agents in patients with severe mental illness reinforced the belief that severe depression is a disease of the brain. However, other patients also present with depressive symptoms precipitated by acute stress (adjustment disorders) and with chronic depression with multiple stress factors and/or due to poor coping skills (dysthymia). Although the validity and specific disease status for many labels in the classification system (Diagnostic and Statistical Manual-IV and International Classification of Diseases-10) are not established, the dominance and use of the medical model implies otherwise. Consequently, the disease label reserved for more severe forms of depression is also applied to people with depressive symptoms secondary to stress and poor coping. The ease of prescribing medication and the investment of time and effort required for cognitive therapy means that psychological intervention is often praised but seldom practised. Antidepressants have become the panacea for loneliness, relationship difficulties, interpersonal conflicts, inability to cope with day-to-day stress, etc.

Another important issue, especially in the western world, is the role of mental health professionals in managing people with mental illness. Many people with distressing social situations and life events present with symptoms of depression. Consequently, the mental health team provides the psychological and social support which was previously provided by the family and local community. However, the provision of such support by mental health professionals mandates the need for medical models, labels and treatments to justify the medical input. Insurance reimbursement also necessitates the use of such labels. Consequently, the psychiatric culture now tends to view all depression and distress as a disease.

THE GENERAL PRACTITIONERS’ PERSPECTIVE
Patients visit general practitioners (GPs) when they are disturbed
or distressed, when they are in pain or are worried about the implications of their symptoms. Bereavement, marital discord, inability to cope at work and financial problems can also lead people to seek help. The difficulty in separating distress from depression becomes important. While psychiatrists suggest that brief screening instruments can easily identify people with depression, most GPs would argue that many of those identified are distressed. The depression encountered by GPs is often viewed as a result of personal and social stress, lifestyle choices or as a product of habitual maladaptive patterns of behaviour. Consequently, GPs often hold psychological and social models of depression.

Most GPs and physicians working in primary care accept the medical model of depression during discussions with psychiatrists and academic GPs. However, low detection and treatment rates suggest that the majority subscribe to non-medical social and academic GPs. The increased prevalence of depression in primary care and the absence of effective medical solutions for ‘depression’ in primary care are often reasons for the reluctance of GPs to accept the medical model of depression.

PRIMARY CARE PSYCHIATRY APPROACH
The increased prevalence of depression in primary care and the low recognition and treatment rates have put the focus on primary care psychiatry. Educating GPs, preparing diagnostic and treatment guidelines and conducting courses to improve their clinical skills have been attempted. However, recent assessments have suggested that such guidelines are often praised but seldom put into clinical practice. Despite pilot field studies and acceptance by academic GPs, the watered-down psychiatric approach, when employed in primary care, has few takers. The culture of primary care psychiatry borrows heavily from academic psychiatry and attempts to adapt it to the reality of primary care. The compromise is uneasy, and difficult to apply in general practice.

THE APPROACH OF THE PHARMACEUTICAL INDUSTRY
The industry has espoused the cause of the medical model for depression. It has aided and abetted the medicalization of personal and social distress to its advantage. The subtle and (more recently) not-so-subtle advertising to influence physicians, psychiatrists and the general population has become brazen. Randomized trials sponsored by the industry have been shown to produce results in favour of their molecules. The lack of access to their databases has denied access to the whole truth. The number of new molecules for anxiety and depression has increased over the past 2 decades but has not produced any major breakthroughs despite increased cost. Sponsoring educational activities and professional psychiatric and user meetings and conferences have helped shape medical and patient opinion. While pharmaceutical companies play a major role in the development and testing of new treatments firmly rooted in the medical model, in actual practice theirs is a culture driven by profit rather than by science.

THE OUTLOOK OF THE GENERAL POPULATION
Surveys of public attitudes suggest that the perception of the general population about depression differs from that espoused by psychiatrists. Social adversity is seen as the cause, people are reluctant to consult their GPs, counselling is the preferred treatment and antidepressants are viewed with suspicion as they are considered addictive. Patients attending primary care hold similar views. People often accept social and psychological models of illness more easily than biological models of disease. Religious models are also popular. Accordingly, the general population also seems to accept multiple (and often contradictory) models of illness. They seek diverse treatments from assorted centres offering healing. The protracted course of most depression secondary to chronic stress, lifestyle and poor coping results in people shopping for solutions. While the medical model is preferred by people seeking treatment from psychiatric centres, non-medical models and cultures are more acceptable to those seeking treatment in primary care settings and in the community.

THE CLASH OF CULTURES
The progressive medicalization of distress has lowered the threshold for tolerance of mild symptoms and for seeking medical attention for such complaints. Symptoms of depression are a part of normal mood, reaction to stress, habitual pattern of coping in people overwhelmed by the demands of life and due to diseases of the brain. A combination of causes often operate in the same patient and mixed presentations are common. Diverse presentations in different settings have spawned contradictory models and divergent cultures of depression and have resulted in a polarized debate.

The changes in the meaning of the word ‘depression’ across time and contexts has also added to the controversy. The word is employed loosely for a variety of conditions. We can only understand the true meaning of words when we read them in their original context. In addition, the ‘category fallacy’ argument, where a category generated and applicable in one culture is not appropriate for other cultures, commonly appreciated and debated in cross-cultural psychiatry, is equally applicable in this context.

The diverse cultures of depression are promoted by powerful interest groups. The pharmaceutical industry has made enormous profits; academics have built careers on the diagnosis and classification of depression; GPs have sought refuge in the label while diverting attention from the causes, nature and extent of human suffering; and politicians have found that depression is a convenient packaging of society’s ills. These diverse interest groups with their divergent models of depression are the cause for the contradictions and conflicts, and contribute to the current confusion.

FUTURE DIRECTIONS
The failure of individual models and cultures to explain all aspects of depression has led to the development and use of multiple models, which argue for the need to accept the many perceptions as partial truths. These models should be viewed as complementary rather than competitive, with some being more valid in a specific context than others.

The interaction between different cultures of depression is similar to the interaction between different cultures, societies and peoples. One can clearly see cultural modifications resulting from intercultural borrowing. However, such interaction is often unidirectional and similar to that described as acculturation. It results in changes in an ‘indigenous culture’ (seen in the general population and among GPs) caused by the imposition of a technologically more ‘advanced culture’ (e.g. biological psychiatry and pharmaceutical culture). The one-way transfer of cultural traits and the shift of psychiatry towards biology are more often
accepted in academia but may be far removed from the social reality of depression in the community.\textsuperscript{14} On the other hand, transculturation, the two-way exchange of cultural traits between societies and cultures, is required for understanding the complex issues related to causation and resolution of human distress and depression.

Despite claims that the current psychiatric diagnostic criteria and classifications are atheoretical, the exclusive focus on signs and symptoms of depression to the complete exclusion of personality, coping skills, stress and social context argue that these are part of the medical model and are reductionistic. Distress and emotions should not be mistaken for psychopathology; fear and apprehension should not be labelled as anxiety, or sadness as depression. Physicians and psychiatrists managing patients with depression should be able to hold multiple models of depression. They should be able to appreciate the diverse cultures of depression and choose appropriate treatment strategies.

The medical model is proposed and defended by the powerful biological psychiatry movement within psychiatry and by the pharmaceutical industry.\textsuperscript{14} However, the other models and cultures of depression emphasizing the psychological and social issues are equally valid in their contexts of primary care and the community, but may lack the academic clout and financial resources to present their points of view. The playing field needs to be levelled so that the whole picture can be appreciated rather than the current scenario where part perceptions predominate. The study of cultures of the ‘less powerful’ will also provide rich insights into the complexity of the problem. There is a need to appreciate the history of depression.

There is also a definite need for dialogue between the different cultures of depression in order to resolve conflicts. GPs, who are in the frontline of managing ‘depression’ seen in primary care and who are subjected to pressures from psychiatry, the pharmaceutical industry and from the general population, will have to re-examine the issues related to the condition. The different ‘cultures of depression’ and the pressures from these divergent perspectives will have to be acknowledged. The issues which need to be re-examined would include: (i) review of the validity of the psychiatric diagnosis of depression in the primary care context; (ii) reassessment of the adequacy of a single label of depression to describe the diverse human context of distress; (iii) acknowledgement of the problems of using a symptom checklist in diagnosing depression; (iv) recognition of the need for diagnostic formulations which clearly state the context, personality factors, acute and chronic stress and coping mechanisms; (v) highlighting that antidepressant medication is not the solution to mild and moderate depression and should be reserved for severe forms of distress;\textsuperscript{15} (vi) re-emphasizing the need to manage stress and alter coping strategies in the treatment of people with such presentations; (vii) de-emphasizing medicalization of personal and social distress; (viii) focusing on other underlying causes of human misery including poverty, unmet needs and lack of rights. There is a need to place each of the models and cultures in their contexts and to investigate the possible range of meanings, intentions, authors, audiences and agendas for each point of view.

Clinically, there is a need to look beyond symptoms and explore personality, life events, situational difficulties and coping strategies in order to comprehensively evaluate biological vulnerability, personality factors and stress. The treatment package for such presentations should include psychological support, general stress reduction strategies and problem-solving techniques for all subjects presenting to primary care with ‘depression’. Antidepressant medication should be reserved for severe forms of depression. A psychosocial formulation of the clinical presentation, background and context would put issues in perspective. There is a need for more pragmatic approaches which move beyond the specific models of depression and narrow ‘cultural’ perspectives.

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