Editorials

Depression as a culture-bound syndrome:

implications for primary care

This month sees the publication of the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-V). Headline features include new diagnostic categories of anxious depression and somatic symptom disorder, and blurring of boundaries between grief and depressive disorder. However its relevance to primary care may be less than anticipated.

According to its predecessor, DSM-IV, culture-bound syndromes are indigenously considered to be 'illnesses', limited to specific societies or culture areas, composed of localised diagnostic categories, and used to frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations.[1] Examples commonly cited include *koro* in eastern Asia, *latah* in Malaysia, and *ataque de nervios* in Latin America.

It can be argued that depression also fulfils the criteria for a culture-bound syndrome, in westernised societies.

Our indigenous beliefs are based on the premise that depression is an illness of common and increasing prevalence, destined to become the second most disabling disease by 2020. These beliefs have societal and cultural limitations. They predominate in anglophone societies, although there is wide variation in their understanding and acceptance within these societies, depending on class, gender and culture.[2] Depression can therefore be understood as a set of localised diagnostic categories, albeit currently operating on a larger scale than other culture-bound syndromes.

> "Our indigenous beliefs are based on the premise that depression is an illness of common and increasing prevalence, destined to become the second most disabling disease by 2020."

VALIDITY AND UTILITY

If depression as a diagnostic category had validity and utility, it could be seen as a universal, transcultural concept. But it has neither. There is no sound evidence for a discrete pathophysiological basis. Recent genetic studies, for example, have demonstrated substantial overlap in single-nucleotide polymorphisms across a wide range of common psychiatric diagnoses, including depression, autism and schizophrenia.[3] Consensus around the precise content of the diagnostic category is intrinsically unstable, as demonstrated by the move in DSM-V to allow grief symptoms to be considered as evidence of depressive disorder after only 2 weeks. There is disagreement among nosologists as to whether the category is too large, confusing normal experiences with illness and encompassing mutually exclusive subsets of depressive disorders;[4] or else too small, ignoring substantial symptomatic overlap with anxiety, pain syndromes, and medically unexplained symptoms.[5] In this issue, Warmenhoven and colleagues[6] suggest that the likelihood of making a diagnosis of depressive disorder in primary care is influenced by the patient's context including their age, the presence of chronic physical conditions, and perceived need for support.

The utility of the diagnosis, that is its worth as a guide towards effective treatment, is also debatable. Evidence for the effectiveness of antidepressant medication, still the mainstay of primary care treatment for depression, is highly contradictory. At one extreme we have a meta-analysis of trials submitted to the US Food and Drugs Administration that found drug–placebo differences increasing in relation to initial severity, with conventional criteria for clinical importance reached only for patients at the upper end of the very severely depressed category.[7] In contrast, a meta-analysis of pharmaceutical trials of two common antidepressants finds that they are effective for major depressive disorder in all age groups, and that baseline severity is not related to treatment advantage over placebo.[8]

PERSPECTIVES

We can perhaps better understand how the diagnostic category of depression frames a set of coherent meanings by looking outside conventional medical perspectives. From a cultural perspective, in western anglophone societies we have developed an ethic of happiness, within which aberrations from the norm are assumed to indicate illness.[9] From a commercial perspective, it makes sense to have a large unitary category of depression as a means of marketing pharmaceutical products, while in insurance-led health systems such categories are a technical means of allowing practitioners to be paid for delivering care. From a professional perspective, GPs like to have a diagnostic category that we feel comfortable with: it allows us a sense of confidence and certainty in understanding and managing otherwise messy human problems. However this does not always confer benefit on our patients. The systematic review by Shaw and colleagues published in this issue[10] concludes that the introduction of clinical performance indicators in the UK for assessing depression severity has had little impact on GP management of depression, or on subsequent remission or treatment response.

Placing the argument about depression as a culture-bound syndrome in geopolitical terms, the hegemonic status of the US as the world's leading superpower means that its cultural norms are currently internationally pervasive. Its commercial and psychiatric penetration of China over the past 20 years, for example, has included Cantonese

> "Depression can therefore be understood as a set of localised diagnostic categories, albeit currently operating on a larger scale than other culture-bound syndromes."

"By 2050 the cultural dominance of depression is likely to be severely challenged."

versions of the DSM-IV manual sponsored by US-based pharmaceutical companies. A diagnostic shift from neurasthenia to depression has seen fluoxetine marketed as baiyoujie, which translates as 'undoer of all kinds of worries or sorrows'.[11]

CULTURES RISE AND FALL

However as cultures rise, so may they fall. China, India, and the Middle East are predicted to become politically and economically dominant in the next 20–30 years, bringing with them very different cultural norms and understandings of health and illness. The unity of the mind and the body, a point of contention in Western societies since Descartes, is much more readily accepted in Chinese, Ayurvedic, and Islamic traditions. There is greater emphasis on social and spiritual dimensions of illness in these societies than is commonly found in Western medical traditions. In Buddhist traditions primacy is given to the concept of *dukkha*, detachment from desire, which recognises the unsatisfactory nature of existence and leads us in directions which may be of value in transcending the sorts of experiences we characterise as depression. By 2050 the cultural dominance of depression is likely to be severely challenged.

So for primary care practitioners, there is good reason to be sceptical about current diagnostic categories of depression. They are based on shaky foundations, and created within cultural boundaries that will be subjected to substantial shifts in the coming decades.

EXPLORING ALTERNATIVES

GPs are already beginning to explore alternatives. An unintended impact of the QOF depression indicators in the UK has been a widespread shift in diagnostic labelling, from depression to low mood. The concept of demoralisation, a disorder of meaning and hope, may make better sense than depression in our understanding of people living with advanced cancers.[12] We would benefit from a fundamental shift in perspective, understanding distressed patients not as passive victims of circumstance but as individuals whose capacity to lead purposeful lives has been temporarily disrupted.[9]

Diagnostic uncertainty does not lead to inaction. We have an engagement with many of our patients: a role in the arbitration and management of their distress. We must continue to acknowledge the suffering they bring into the consulting room. Empathy is crucial, and so is our willingness to listen. If the new QOF indicator for depression genuinely encourages our consultations to switch from severity ratings to asking our patients about their physical, psychological, and social circumstances, then so much the better. But labelling and diagnosis do not necessarily follow. Instead we may wish to propose ideas for change, suggest different, less problem-oriented ways of understanding, and encourage new possibilities for social, communal action. Above all, we retain the responsibility to offer hope of an alternative.

Christopher Dowrick,
Professor of Primary Medical Care, Institute of Psychology Health and Society, University of Liverpool, Liverpool.

Provenance
Commissioned; not externally peer reviewed.

DOI:10.3399/bjgp13X665189

ADDRESS FOR CORRESPONDENCE

Christopher Dowrick
1st Floor, Block B Waterhouse Buildings, University of Liverpool, Liverpool, L69 3GL, UK.

E-mail: cfd@liv.ac.uk

REFERENCES

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th edn. Arlington, VA: American Psychiatric Publishing, 2000: 898–890.
2. Karasz A. Cultural differences in conceptual models of depression. *Soc Sci Med* 2005; **60(7):** 1625–1635.
3. Cross-Disorder Group of the Psychiatric Genomics Consortium. Identification of risk loci with shared effects on five major psychiatric disorders: a genome-wide analysis. *Lancet* 2013. DOI:10.1016/S0140-6736(12)62129-1.
4. Parker G, Fletcher K, Hyett M, *et al*. Measuring melancholia: the utility of a prototypic symptom approach. *Psychol Med* 2009; **39(6):** 989–998.
5. Shorter E, Tyrer P. Separation of anxiety and depressive disorders: blind alley in psychopharmacology and classification of disease. *BMJ* 2003; **327(7407):** 158–160.
6. Warmenhoven F, Bor H, Lucassen P, *et al*. Depressive disorder in the last phase of life in patients with cardiovascular disease, cancer and COPD: data from a 20 year follow-up period in general practice. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X667150.
7. Kirsch I, Deacon BJ, Huedo-Medina TB, *et al*. Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. *PLoS Med* 2008; **5(2):** e45.
8. Gibbons RD, Hur K, Brown CH, *et al*. Benefits from antidepressants: synthesis of 6-week patient-level outcomes from double-blind placebo-controlled randomized trials of fluoxetine and venlafaxine. *Arch Gen Psychiatry* 2012; **69(6):** 572–579.
9. Dowrick C. *Beyond depression*. 2nd edn. Oxford: Oxford University Press, 2009.
10. Shaw EJ, Sutcliffe D, Lacey T, Stokes, T. Assessing depression severity using the UK Quality Outcome Framework depression indicators: a systematic review. *Br J Gen Pract* 2013; DOI: 10.3399/bjgp13X667169.
11. Lee S, Kleinman A. Are somatoform disorders changing with time? The case of neurasthenia in China. *Psychosom Med* 2007; **69(9):** 846–849.
12. Lloyd-Williams M, Reeve J, Kissane D. Distress in palliative care patients: developing patient-centred approaches to clinical management. *Eur J Cancer* 2008; **44(8):** 1133–1138.