Depression in Cultural and Global Context

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The following script evaluates depression in a cross-cultural context and examines
perspectives and treatment.

1. Defining Depression

Depression is defined as a mood disorder accompanied by sleeplessness, fatigue and low self-esteem, diagnosed when present for at least two weeks under DSM (Glassman & Hadad, 2008, p.418). Symptomatic are negative ‘automatic thoughts’ and the perception of loss, deprivation, defeat, and not being loved. It often leads to withdrawal, self-isolation and a general negative cognitive shift (Beck, 1991). In the worst case the evoked hopelessness can lead to suicide.

The World Health Organization mentions that depression is globally already the second cause of DALYs (Disability Adjusted Life Years) for people between 15-44 years of age for both sexes combined. Between 15-20% patients with depression eventually commit suicide (WHO, 2012). This renders suicide rates a reliable indirect indicator for depression: not all people with depression kill themselves, but those who do commit suicide motivated by a depressed state of mind.

2. Suicide rates in Switzerland, Germany and Thailand: The Cultural Divide

Nothing seems more contradictory than statistics. In the ‘World Happiness Report’ (Helliwell et. al, 2012) countries like Denmark, Switzerland and Finland appear as the happiest nations in the world by international comparison and based on clusters of criteria. Paradoxically however the suicide rate per 100,000 persons for males in Switzerland is as high as 24.8 (2007), compared to Germany with 17.9 (2006) and Thailand with 12.0 (2002), less than half the rate of Switzerland. The suicide rate for women in the same years is 11.4 for Switzerland, 6.0 in Germany and only 3.8 in Thailand (WHO, 2012), a third the rate of Switzerland. Although we find many countries with suicide rates way lower (like Peru or South Africa), Thailand still appears to be a ‘Land of Smiles’. Within Thailand the highest suicide rates can be found in the impoverished Northern provinces (Ministry of Public Health of Thailand, 2010), confirming partially a hypothesis of Martin Seligman that below a certain income level people do get increasingly unhappier. Amphetamine-abuse is quoted as another common factor leading to depression and suicides in Thailand. If we square off poverty-based factors the question arises which factors remain as genuine culturally-based causes for depression and which factors contribute to its inhibition.
Among middle-class Thais I have not come across a single person suffering from depression in the seven years I live in Bangkok (an observation shared with many others foreigners), whereby among my Western friends the majority, myself included, suffer from some form of depression. The world’s most depressing places, based on leading male suicide rates, appear to be Lithuania with 61.3 (WHO, 2009) and the Russian Federation with 53.9 (WHO, 2006).

3. Most likely culturally-related causes

Aaron Beck mentions two types of individuals, socio-tropic and autonomous (Beck, 1991). In individualistic cultures such as Germany autonomy and performance are highly valued; therefore failure or the sudden inability to compete can create depression. In socio-centered societies like Thailand where people grow up in close-nit social networks, individuals are prone to depression after what Beck calls ‘sociotropic traumas’, such as social deprivation, isolation and rejection. In both cases depression seems to carry a profound cultural factor. For example, Singapore advocates a Western-style model based on individual performance. Suicide rates with 12.9 for males and 7.7 for females are comparable to many Western countries. In Singapore the breakdown of communication between parents and their children, the disintegration of traditional family bonds, is cited as a major reason of relatively high suicide rates among the young (Lee Hui Chieh, 2003), based on a study for the Singapore Institute of Mental Health (IMH). For Thailand suicide rates are surprisingly dropping. Dr. Apichai Mongkol of the public health department was quoted "Stress alone does not lead to suicide, but the feeling of being inferior certainly does. People in the southernmost provinces were certainly stressed by the on-going violence, but they had the lowest suicide rate and a recent study found their mental health was as good as people living in other regions. This is because good mental health is not just about stress, but also about the persons' ability to adapt themselves and assist others, which is what was happening in the Deep South." (The Nation, 2007). Loneliness and living in single families are emerging trends that are quoted as further major causes for depression in Thailand.

3. Treatment options

Depression is regarded to have both, a psychological as well as a physiological component and therefore cognitive therapy (CT) as well as treatment with anti-depressants are commonly considered, in rare cases a combination of both (Schwartz & Petersen, 2009, p.36). The controversy on the long-term efficacy of using anti-depressants is ongoing (Glassman & Hadad, 2008, p. 421). A friend of mine who is suffering from bi-polar disorder for example discontinued anti-depressants with the argument to gladly trade in depression for feeling human again and not being ‘zombified’ by drug-regimes.

CT, psychotherapy and theorists like Beck and Ellis focus on how, what and why we think negatively. If we assume that many significant stressors are environmentally-based, CT appears a logical approach as it addresses the cause and not only symptoms of depression.
This may explain the high success rate of CT for fear and anxiety disorders (Glassman & Hadad, 2008, p. 435). The behaviorist approach falls short in efficacy as we do not learn depression directly from others, at least not on interpersonal level.

The individual concepts of depression do however not take into account external factors such as political and economic deterioration, lifestyle, education and culture. Since depression is globally one of the most prevalent mental disorders, an investigation into its extrinsic factors seems more than warranted. Who knows, future treatment options may include life-style therapy.

4. Discussion and Conclusion

A recent study conducted for the WHO confirms that richer countries have a significantly higher depression rate than poorer countries. The survey published in BMC medicine by Evelyn Bromet and colleagues was based on 90 000 interviews in 18 countries. The USA is leading in depression with a lifetime rate of 19.3 % (Bromet et al., 2011). Middle-to-low income countries such as India, Mexico, China and South Africa scored with below 10% the lowest. Based on the data: what if depression is, despite assumed in the DSM as an individual disorder, is in fact based to a great extend on cultural stressors? This notion spans from the earliest relationships of mothers to their children to upbringing and generally a highly socialized life-style avoiding isolation, compensating faster for failure and not perceiving conformity as a threat to autonomy. Since poorer nations are mostly socio-centered societies this suggests causal relationships. Or to ask more provocatively: Could even neuronal medical manifestations of depression be the effect of continuous cultural ill-conditioning?
References


