
Depression: Classification, Culture and the Westernisation of Mental Illness

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1. Introduction

In this era of functional MRIs, neurobiology and the sequencing of the human genome, it is easy to forget that the complex phenomenon of mental illness is to some degree socially constructed. The trend towards globalisation has seen a Western social bias (one could even say an American bias) towards the classification and treatment of mental illness.

In this chapter we argue that the homogenisation of the experience, classification and treatment of mental illness, whilst having some benefits, has also done harm and that this is especially true of the complex phenomenon of depression.

The chapter examines:

- the effects of the Diagnostic and Statistical Manual on the homogenisation and simplification of mental illness and in particular depression,
- the phenomenology of depression across cultures in light of the Westernisation of mental illness, and,
- the role of “Big Pharma” in pathologising the cultural expression of sadness.

In addition, the chapter will suggest some ways forward to a more nuanced approach to the diagnosis and treatment of depression.

1.1. Introduction: Surface symptoms and aetiology

Sarah’s depression

Sarah had been diagnosed with depression following the death of her much loved father some eighteen months previously. Her symptoms were severe enough for her to be diag-

nosed with the DSM-IV category of Major Depression. The prescribed medication had helped somewhat but some two and a half years after her father's death her depression and its accompanying anxiety saw this once confident woman lose her business and her marriage.

Sarah was eventually referred to a group and individual psychotherapy program. In this program Sarah told the story of her father's death. Her father had been scheduled for a hip replacement. The surgery was delayed and his eventual admission coincided with Sarah's scheduled move to a distant city to set up a new business. The surgery went ahead but Sarah's father developed postoperative pneumonia. Not wishing to alarm Sarah and necessitate her unnecessary return, her sister Jane, expecting their father to recover quickly, kept the information from Sarah. However their father's condition deteriorated and by the time Sarah was notified it was too late and her father died whilst she was on a flight home.

All of this was explored in therapy but Sarah's symptoms remained. Then some months into therapy Sarah was notified that her mother had suddenly become ill and had been admitted to the same hospital. Sarah arrived at the hospital in good time and was able to be with her mother up until her death. Shortly before her death her mother began talking to her dead husband as if he were in the room with them.

On returning back to therapy following her mother's funeral Sarah seemed to have changed. Sarah related that when her mother was talking to her dead father Sarah remembered her last conversation with him: something she had hitherto forgotten. She had gone to see him prior to his operation and her travel interstate. Her father, who had never been in hospital before, appeared anxious and said to Sarah, "You are leaving me here to die". She assured him that he would be fine and back on his feet in no time.

Reflecting on this in therapy Sarah was surprised that she had forgotten the comment and reflected on the fact that she had indeed left him to die, albeit unknowingly. In the following weeks Sarah went over this comment time and again; she had not meant to leave him to die, it was not deliberate. Sarah then went through a period of grieving for both her parents and the grief turned to a period of mourning at their passing. Gradually over the following months Sarah's depression and anxiety lifted. At six and twelve months follow-up her depression and anxiety had not returned.

Carolyn's agoraphobia

Carolyn's Agoraphobia had begun without any identifiable cause. Following a panic attack in a supermarket checkout queue she found it increasingly difficult to go out in public. Cognitive Behaviour Therapy (CBT) and anxiolytics had helped a little but her anxiety and accompanying depressive symptoms persisted.

Carolyn was eventually referred to individual and group psychotherapy. Progress was slow and Carolyn's anxiety made it difficult to travel to therapy. Some weeks after commencing group therapy, a group member brought up the topic of loss. This client spoke of the loss of a child as being the greatest loss one could suffer. Carolyn broke down and began crying uncontrollably. Over the next few sessions she recounted how twenty-five years previously she had been admitted to hospital following complications of her

first pregnancy and subsequently suffered a late miscarriage. She recounted how today it would have been considered a still birth, how she had not been allowed to see the baby and how she was told to forget about it and try to get pregnant again. Her husband and her family never mentioned it again.

Over subsequent group therapy sessions Carolyn recounted the days and months following the "miscarriage". She recounted how she had tried to put on a brave face and not cry and how secretly she went back to the hospital and asked where the child's grave was, only to be told there wasn't one. She had not spoken to anyone about it from that day to this. Over the following weeks she cried, "Twenty five years worth of tears". Gradually, Carolyn's symptoms of anxiety and depression subsided and she found herself once more able to go out in public without fear of a panic attack.

What do these two stories have to say about depression? In both cases the clients had been diagnosed and treated with medication which had some affect on the symptoms but did not bring about a resolution of the problem. In the case of Carolyn, Cognitive Behaviour Therapy was used and once again had some affect but did not resolve the problem. Both the medication and the CBT were used to treat the surface symptoms. As Darian Leader puts it, the consequence of treating the surface symptoms is that, "The interior life of the sufferer is left un-examined, and priority given to medicalizing solutions...The problem has to be got rid of rather than understood (Leader, 2008:2)". Medication in this case aimed to restore presumed chemical imbalances in the brain. CBT was aimed at restoring presumed faulty cognition. In both cases the underlying loss was left untouched and in fact remained hidden. In Sarah's case the guilt associated with her father's death and the loss of her identity as a dutiful daughter remained hidden even from her. In Carolyn's case the surface symptoms which were predominately of anxiety, meant that grief and loss were not even associated with her case and were masked as much by the diagnosis as anything else. This concentration on the appearance, diagnosis and surface symptoms effectively blocked a deeper and more wide ranging explanation of the symptoms.

The other interesting element of both cases is that the surfacing of the underlying loss and its subsequent resolution took time. Time is one thing we often do not have for clients in today's world: time for them to explore their reality and, as the experts of their own experience, to teach us. Indeed in some countries psychiatrists spend on average two hours per year in face-to-face dialogue with clients (Leader, 2011). Sarah and Carolyn's recovery also took place within an alliance with others. Both women underwent a period of public (albeit within the group) mourning in which both appeared to integrate their experiences into their life story.

In this chapter we shall explore the consequences of classifying and treating depression based upon the surface symptoms. We shall also explore how culture and context influence surface symptomatology. We suggest a way forward which acknowledges our shared humanity and the need to look beyond surface symptomatology in the treatment of depression.

2. The effects of the diagnostic and statistical manual on the homogenisation and simplification of mental illness and in particular depression

Naming something does not explain it.

In the 1960s many school biology classes taught that the Platypus was a “freak of nature”: as it suckled its young and laid eggs it was neither a mammal nor a reptile. Of course because something does not fit neatly into a human classification system does not make it a “freak of nature”. To believe so is to believe that by naming something we have explained it. Yet to some extent this is what we are doing when, using a diagnostic system based on surface symptoms or descriptions, we classify human behaviour as this or that disorder: the diagnosis becomes the explanation for the symptoms. Whilst there are undoubted advantages to standard classification systems (communication between clinicians; ability to examine the natural history of a disorder and develop targeted treatment regimens) the major disadvantage is that the individual, their experience, their inner life, their uniqueness, their humanity culture and context, can be overlooked or ignored and the surface symptoms alone treated.

The debate about psychiatric classification and its consequences is not new. The debate has generally revolved around description versus aetiology. Kraepelin believed that pure description would eventually lead to and be replaced by a system based on aetiology (Zigler & Phillips, 1961). Unfortunately this has not happened.

The danger with an emphasis on description is that it may leave little room for the interpretation of psychopathology (Zigler & Phillips, 1961). In addition if the descriptions are drawn from one dominant cultural perspective then from the beginning their cross-cultural universality should be questioned. In such a system, the manifestations of mental illness may be forced to fit preconceived frameworks and paradoxically the zeal for classification may see more and more human behaviour pathologised.

The dominant classification system in the world is the American Psychiatric Association’s (APA) Diagnostic and Statistical Manual (DSM) of Mental Disorders: now about to be released in its fifth version. Whilst the DSM has assisted clear communication between physicians when discussing mental illness and its treatment, it has also been accused of medicalising (and therefore pathologising) an ever-increasing range of behaviours (Flaskerud, 2010). The original DSM I, which was first published in 1952, contained 103 diagnoses; by the publication of DSM-IV-TR in 2000 this had grown to 365. This growth in diagnostic categories has not been without its critics. The APA has been accused of manufacturing madness by pathologising a wider and wider spread of human behaviour. This has been achieved, say the critics through devising new diagnostic categories and broadening the criteria for the old ones. The most recent controversy surrounds the suggestion by the APA that the new edition of the DSM remove the bereavement exclusion in the diagnosis of major depression and add complicated grief as a new diagnosis (Frances et al, 2010).

That the DSM is a descriptive classification system is clear. The DSM-IV-TR (APA, 2000) in addition to listing surface symptoms, also discusses prevalence, course, familial pattern

and differential diagnosis but not aetiology. As a consequence of its purely descriptive stance there have been those who argue that the DSM lacks validity as it is a classification system without a theoretical/explanatory basis or an agreed upon scientific model other than a general assumption of a biological causation of mental illness (Thakker & Ward, 1998; Flaskerud, 2010).

According to Gary Greenberg (2010, p. 15) "the DSM is an unparalleled literary achievement. It renders the varieties of our psychospiritual suffering without any comment on where it comes from, what it means, or what ought to be done about it".

Criticisms of the DSM are abundant and we do not propose to outline them all here. However there are some points of critique which are of relevance to this chapter. The first is the imposition of a North American/Western European perspective on mental illness and the relegation of other cultural perspectives to curiosity status. The second is the mistake of thinking we are describing stable entities when what are really being described are also socio-political constructs.

That the DSM has a North American/Western European bias is evident. The DSM-IV-TR (2000) relegates non-western syndromes to an appendix called "culture-bound syndromes (APA, 2000: 897-903)". This ignores the fact that the DSM itself is culture bound and a product of North American Western European culture (Flaskerud, 2010). It further assumes the universality of its primary syndromes, some minor culture bound influences aside (Thakker and Ward, 1998). The socio-political construction of the DSM, even within its own cultural paradigm, is well illustrated by the fact that the mental disorder of homosexuality was cured with a stroke of a pen when it was eliminated from the DSM II in 1974 (Flaskerud, 2010). Prior to this societal change, homosexuality was deemed a mental illness and treated by various means including aversion therapy.

A mental disorder is defined as the "existence of a clinically recognisable set of symptoms or behaviour associated in most cases with distress and with interference with personal functions" (ICD-10, World Health Organisation (WHO), 1992, p. 5). A person is considered to have a mental illness when the clinical presentation meets the criteria defined either in the DSM-IV (APA, 2000) or the ICD-10 (WHO, 1992). Conversely, a mentally healthy person will not exhibit clinically recognisable symptoms, behaviours or functional distress.

Importantly, the diagnostic process for any person is concerned with the accurate assessment by the clinician. This assessment occurs through the interaction between the clinician and the client and is based on an interrogatory process. Any examination of the rates of mental illness within a given community rests on the assumption that the diagnosis is accurate. Forming an accurate diagnosis is based on a number of factors including cultural variances in the expression of mental illness and cross-cultural communication patterns. Self-disclosure by the client in the assessment procedure is a communication variable that influences the nature and amount of information the clinician is able to secure during the interview. Clinicians therefore, need to be culturally sensitive to the differences in communication practices within cultures that affect self-disclosure as well as the cultural differences in illness expression and help-seeking behaviour.

According to Marsella (1981) any ideas relating to mental health must be viewed in the context of what constitutes “the self”. Given that cultures ascribe and define notions of self, reality and illness, it is fundamental to study mental health and illness in a holistic framework with regard to social, contextual and cultural history (Marsella & White, 1982). “Cultural conventions about the self, reality, social rules, and patterns of emotional expression, for example, simply make universal criteria of psychiatric illness difficult to attain and the idea itself problematical” (Fabrega, 1987, p. 386).

Burr and Chapman (1998) argue that psychiatry has pathologised culture by perpetuating cultural stereotypes as definable categories and failing to acknowledge the institutionalised racism that exists. Moreover, these authors argue that,

“Health carers seem to be characterised as either cultural translators or functionaries, whose practice is largely circumscribed by a social system characterised by social and economic inequality” (Burr & Chapman, 1998, p. 435).

Historically, there have been challenges to the assumptions that cross-cultural similarities in abnormality exist. Earlier, cultural anthropologists suggested that abnormality was relative and should be addressed in conjunction with the cultural norms and deviations tolerated relative to that society (Kleinman, 1996). Since these early warnings questioning the validity of applying non-specific diagnostic criteria to non-Western social groups, a number of studies have empirically demonstrated the need to define concepts of normality and abnormality according to normative standards relevant to reference populations (Kleinman, 1996).

The concept of mental health has traditionally been embedded in psychological and behavioural characteristics. According to MedlinePlus (2012) “Mental health is how we think, feel and act as we cope with life. It also helps determine how we handle stress, relate to others and make choices. Like physical health, mental health is important at every stage of life, from childhood and adolescence through adulthood”. Somatic expressions have until recently largely been ignored mostly due to the scientific models that have defined illness. Models of causality are now including epistemological and ontological paradigms, which interact to identify mental illness across many cultures (Marsella, 1981). Although some (APA, 1994; Gaw, 2001, Weller & Baer, 2008) would argue that there are identifiable and unique “culture-bound syndromes”, these syndromes are also found across quite disparate cultures.

In parallel with the rise of a descriptive nosology has been the rise of the biomedical model of causation of mental illness. This model assumes that mental illness including depression arises from chemical imbalances in the brain, which in turn may have a genetic cause. The consequence of this pairing of a descriptive nosology with a biological causation has been that contextual factors or the life world of the patient as well as their inner life world are seen as much less important to both understanding and treating depression. It has also seen the rise and rise of pharmacological treatments especially since the advent of the SSRIs starting with Prozac in 1988. Of this more later.

Regier (2004, p. 25) describes the problem: Various critics of the current diagnostic system have characterised the expansion of diagnostic categories as a “guild” attempt to justify payment for any condition a psychiatrist might see in practice, or as fabrications of the pharmaceutical industry to justify the sale of their products”.

3. An “Epidemic” of depression?

According to the World Health Organisation (2012), depression is the leading cause of disability as measured by years lived with disability (YLD) and the 4th leading contributor to the global burden of disease in 2000 (WHO 2012). By 2020 depression is projected to be the second highest ranked cause of years of productive life lost due to disability (DALYs). Various reasons for this apparent epidemic have been posited varying from the rise of individualism (Ehrenreich, 2007) and dissolution of a sense of community (Levine, 2008) to, paradoxically, the use of anti-depressants as front-line treatment for depression (Whitaker, 2011).

However, behind the alarming statistics and the posited causes, the influence of a descriptive classification system, depression awareness campaigns and the marketing of antidepressants by drug companies, makes the picture even less clear.

As previously stated, the classification of depression is based upon surface symptoms from a predominately North American/Western European perspective. The term depression has come to replace earlier terms such as “melancholia” and “mourning” which subsumed depressive symptoms within them and at least hinted at contextual factors. The DSM has elevated depression from a symptom to a disorder. Whilst the DSM has a definition and set criteria for depression, the term has a variety of meanings to the general public; both figurative and literal (Summerfield, 2006). Coupled with this is the global campaign to raise awareness of the disease so that treatment can be effected and the “epidemic” fought.

In Australia, the spearhead of this campaign is the not for profit organisation “Beyond Blue” (www.beyondblue.org.au). The Beyond Blue website contains symptom checklists some of which are so broad that many people may be concerned that they are in fact depressed. For example, the website contains the SPHERE symptom checklist which is a “... scale developed as part of a national mental health educational project aimed at increasing GP’s rate of identification, effective treatment and management of common psychological disorders like depression” (Beyond Blue website). The scale contains 27 items grouped under behaviours, thoughts, feelings and physical symptoms. On entering four symptoms at random into the checklist (“not getting things done”, “it’s my fault”, “indecisive” and “tired all the time”) the site advised that: “If you scored 3 or more of the [27] symptoms, you *probably have a depressive illness* [emphasis added]”, and should see a doctor. Contextual factors are not taken into consideration.

The doctor that most people undertaking such a symptoms test will see will likely be a General Practitioner (GP). Dumit (2005) states that in the USA 75% of all prescriptions for antidepressants are written by non-psychiatrists. GPs are increasingly facing clients armed with

symptom checklists, often supplied by drug companies, which may influence prescribing behaviour (Dumit, 2005). The situation in the UK is similar. Summerfield (2006) states that whilst there is little empirical evidence for an epidemic of depression, with prescriptions for antidepressants rising in the UK in the 1990s from 9 million to 21 million, there is evidence of an epidemic of prescribing. We are now seeing the diagnosis of depression and the prescription of SSRIs rising in non western countries.

4. The phenomenology of depression across cultures and the westernisation of mental illness: The case of Japan

Depression is a complex phenomenon. It is experienced by different individuals in different ways. The phenomenology of depression is also influenced by the cultural context. For example, in the West people diagnosed with depression are likely to present with predominantly psychological symptoms. That in other parts of the world somatic symptoms tend to dominate has long been known (Ryder, 2008; Tanaka-Matsumi & Marsella, 1976). That different cultures view depression and the expression of sadness in different ways is also well known. Indeed, until recently this was also the case in Japan. Sadness and depression were often positively viewed as "... yielding enhanced awareness of the transient nature of the world (Kirmayer, 2002)". Up until the 1990s "Utsubyô" (the Japanese term for depression) was considered a severe but rare disorder (Watters, 2010). Other lesser forms of depression were seen as a personal affliction which did not require treatment (Kirmayer, 2002).

However, the Japanese attitude to depression changed dramatically in the late 1990s when Japan saw a 46% increase in cases of depression diagnosed between 1999 and 2003. In 2005 it was estimated that 2 million Japanese suffered from depression as defined by the DSM (Schulz, 2004). Although the rate of suicide in Japan is much higher than other countries (twice that of USA and four times that of UK), the prevalence of depression is still lower than the USA and only 53% of suicides are attributed to depression (Sado et al 2011). Nevertheless the Japanese experience mirrors reports in the professional and popular press of an "Epidemic of Depression" (Levine, 2008). This epidemic of depression has set alarm bells ringing in Japan not least because on the economic front alone it has been estimated that the total cost of depression in Japan in 2005 was ¥2 Trillion (Sado, et al 2011).

Interestingly this rise of depression in Japan coincided with the rise in the use of the DSM and the marketing of SSRI antidepressants.

The DSM 111 was introduced to Japan in 1980 but its uptake was slow. The conventional classification of mental illness had been influenced by German neuropsychiatry of the early 20th century (Someya, 2001, Kirmayer, 2002). However, by 2000 there was a general acceptance and use of the DSM by the younger generation of psychiatrists (Someya, et al 2001).

Whilst there is some evidence that the cardinal symptoms of depression as described in the DSM appear as clusters or syndromes in many cultures, there are many other symptoms that reflect cultural idioms of distress and "ethnopsychologies" (Kirmayer, 2002). As globali-

sation takes hold and a degree of cultural homogenisation takes place there may well be a shift in these culture bound manifestations which reflect a shifting globalised perspective on distress and the individual's place in society. Such homogenisation may see the descriptive nosology of the DSM adopted as the standard across cultures. As Kirmayer puts it,

"The notion that a comprehensive or complete nosology can be created without regard to culture and context can be sustained only by adopting a reductionistic perspective that ignores the fact that human beings are fundamentally cultural beings (Kirmayer, 2005:193)".

5. Westernisation of depression the role of "big pharma"

Given Japanese cultural views of depression, it is not surprising that Japan was not seen as a large market for antidepressants. However, that changed in the late 1990s when drug company GlaxoSmithKline began marketing its new SSRI, Paxil (Watters, 2010).

The campaign began with the GlaxoSmithKline convening a group of experts in cross cultural psychiatry in order to promote the concept of depression in Japan and reconceptualise somatic symptoms and social anxieties as indicators of an illness amenable to pharmacological treatment (Kirmayer, 2006). One more cynical aspect of this campaign was the marketing of depression as a "kokoro no kaze": cold of the soul (Watters, 2010) for which the remedy was a kind of psychic Aspirin; an SSRI.

Whilst the upshot of this campaign may well have been the treatment of Japanese people who had hitherto been undertreated or not treated at all for depression, the subsequent drug company community information media campaign aimed to broaden the market for SSRIs in Japan. This was achieved by presenting depression as "...intentionally ambiguous and ill-defined, applicable to the widest possible population and to the widest possible range of discomforts (Kitanaka, 2006 quoted in Watters, 2010: 226)". Whilst in no way a cynical or a deliberate attempt to mislead, the symptoms checklists seen on the Beyond Blue website may have a similar effect in that three or more vague discomforts of the common lot for humanity which coincide with a two week period of depressed mood are seen as "probably" indicating depression.

The GlaxoSmithKline community information campaign in Japan may have also been aimed to overcome another barrier to the diagnosis and treatment of depression: stigma. Again, this may have been of benefit for some Japanese suffers of depression as stigma is a barrier to many individuals who would otherwise seek treatment (Cross and Walsh; 2012). Dumit, however, takes a more cynical view: "Marketers see stigma as inhibiting self recognition of patient status and therefore reducing prescription demand (Dumit, 2005)". Indeed Dumit believes that differences in diagnosis between races or genders are seen by drug marketers as an opportunity to achieve "parity". In this way the lesser market [Japan for example] is

seen as 'undertreated'. Efforts to open up the market and achieve parity are characterised by "...the funding of epidemiological studies, the introduction and invention of new languages and the creation of websites explaininis seen by drugg the symptomatology of the conditions (Dumit, 2005:11)". This has seen an interesting shift from previous expressions of illness and suffering in which the patient's experience of suffering and identification as a sufferer took primacy over one where it is possible for the patient to be a sufferer without knowing it. Indeed the patient may need to be assisted to develop insight into their state by public service campaigns, drug company information, experts in the field, symptoms checklists and diagnostic manuals. Objective opinion takes precedence over subjective experience.

Overall there appears to be a lowering of the threshold for symptomatic treatment of depression. For some commentators this amounts to "disease mongering" which interferes with the individual's coping mechanisms and culturally appropriate ways of dealing with distress (Das, 2011).

The increasing pathologising and medicalising of human behaviour has been well documented (Greenberg, 2010). Some see this as evidence of the rise of the medical-industrial complex (Das, 2011) and the manufacturing of illness (and attendant cures). However, it also brings into question notions of happiness and expectations of the human condition in contemporary society.

6. A way forward

In North American/Western European societies the story of depression is illustrative of a deeper malaise which in turn is being exported to other cultures. This malaise includes: an uncritical adoption of a descriptive nosology of mental illness; the gradual broadening of what constitutes mental distress; simplistic genetic and biological models of causation with attendant simplistic pharmacological treatments.

This has had a number of consequences. The gradual broadening of the definition of mental disorders and the lowering of thresholds for diagnostic categories has seen hitherto unpathologised human experience pathologised (Atrens, 2011). This has brought about a fundamental change in expectations of what life should bring and in fundamental notions of happiness, suffering and what it means to be human. This situation is nicely satirised by a slogan on the T shirt seen recently: "I used to care but I take a pill for that now." Not only is there change in the expectations of what constitutes suffering and the human experience, there is another more insidious effect. If the cause of our problems resides in our biology, our neurones and our genetics, then it is, at its core, a problem of the individual. This splitting of the individual from their society and context is analogous to the focus on surface symptoms discussed earlier. The surface symptoms of the deeper malaise in our societies is the disorder of the individual. The cure then is to treat the individual rather than explore the part that society, culture and context plays and therefore need for social reform.

There is little doubt that the suffering and disability (and indeed mortality) caused by severe depression needs to be alleviated wherever possible and in all cultures. It is however less

clear that lesser forms of unhappiness, dissatisfaction or distress require a medical diagnosis and pharmacological treatments. This is even more the case where cultural and other differences are poorly understood. Collectivist societies (such as those commonly found in Asia and Africa) will differ markedly in their expression of sadness and depression and will often require a different approach to individualist societies. Nevertheless, it could be argued that underlying issues of separation and loss are common across cultures (Leader, 2008) but the culture then shapes the expression of the surface symptoms.

Descriptive nosologies, simplistic biological models of causation and the attendant emphasis on pharmacological treatments may not be helping to alleviate mental distress but may be making it worse (Atrens, 2011).

As Kirmayer states:

Health and illness reside not just in the individual but also in networks of relationships that are culturally defined. The creation of discrete disorders involves bracketing off social context. A comprehensive psychiatric nosology must reserve a place for human predicaments. Rather than focusing exclusively on problems presumed to be intrinsic to the person, or even to the central nervous system, we need to continue to develop and refine a typology of the range of human predicaments (Kirmayer, 2005:195).

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