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Special research report

Culturally-sensitive complaints of depressions and anxieties in women

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Abstract

Background: Current classifications of Mental Disorders are centered on Westernized concepts and constructs. “Cross-cultural sensitivity” emphasizes culturally-appropriate translations of symptoms and questions, assuming that concepts and constructs are applicable.
Methods: Groups and individual psychiatrists from various cultures from Asia, Latin America, North Africa and Eastern Europe prepared descriptions of main symptoms and complaints of treatment-seeking women in their cultures, which are interpreted by clinicians as a manifestation of a clinically-relevant dysphoric disorder. They also transliterated the expressions of DSM IV criteria of main dysphoric disorders in their cultures.
Results: In many non-western cultures the symptoms and constructs that are interpreted and treated as dysphoric disorders are mostly somatic and are different from the Western-centered DSM or ICD systems. In many cases the DSM and ICD criteria of depression and anxieties are not even acknowledged by patients.
Limitations: The descriptive approach reported here is a preliminary step which involved local but Westernized clinicians-investigators following a biomedical thinking. It should be followed by a more systematic–comprehensive surveys in each culture.

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Conclusions: Westernized concepts and constructs of mental order and disorders are not necessarily universally applicable. Culturally-sensitive phenomena, treatments and treatment responses may be diversified. Attempts at their cross-cultural harmonization should take into consideration complex interactional multi-dimensional processes.

Keywords: Depression; Anxiety; Women; Cross-cultural

1. Introduction

In many countries and cultures, mental health diagnosis and services are based on the World Health Organization (WHO) International Classification of Diseases Tenth Edition (ICD-10). Increasingly, the practice, diagnosis and research of mental disorders is influenced by the American Psychiatric Association (APA) Diagnostic and Statistical Manual of Mental Disorders – DSM IV (APA, 1994). Several structured diagnostic interviews have been developed in order to arrive at DSM IV diagnostic entities, including the American-centered SCID (Structured Clinical Interview for DSM IV) (Spitzer et al., 1992) and several versions of the Composite International Diagnostic Interview – CIDI (WHO, 1990). The CIDI has been reported to be useful also in clinical settings (e.g. Wittchen, 1994) and to be of adequate validity and reliability in multiple sites participating in International multi-center studies (Wittchen, 1994; Kessler, 1999; Barkow et al., 2002).

Although current biomedical diagnostic systems and the instruments derived from them are presumably designed to reflect the presentation of mental disorders across cultures, in reality they are more heavily biased towards descriptions of psychiatric disorders in European and North-American cultural contexts.

In any diagnostic system and in corresponding structured instruments used to arrive at identification of diagnostic entities or categories, several culturally-sensitive biases are of consideration. a) Construct bias – related to non-equivalence of constructs across cultural groups. b) Method bias – resulting from instrument administration problems. c) Item biases – often are result of inadequate translations such as incorrect word choice (Van de Vijver and Leung, 1997). Universality of psychiatric constructs of depression was already questioned by Kleinman (1977), who suggested that different ways of understanding body and self could result in substantial differences in psychopathology. Thus, somatization may be a distinctive feature of a depressive experience (Kleinman, 1977, 1986) in some cultures, while in others, psychological expressions might be dominant. The currently widely assumed cross-cultural portability of psychiatric theory, diagnosis and practice may also be challenged (Kirmayer, 2006). It may be replaced by an interdisciplinary (psychiatry, epidemiology, medical anthropology, sociology, cognitive and social psychology as well as neurosciences) perception of culture as a biologically meaningful construct in which both local and global contexts of knowledge and ethnocultural–political–economic forces are shaping phenomena and being shaped by them (Leighton, 1981; Kirmayer, 2006).

Construct bias is usually studied with factor analysis and multi-trait – multi-method validation, preferably with a gold-standard instrument (Reynolds, 2000).

However, prior to large scale studies, a qualitative–descriptive exploration of culturally-sensitive expressions may be required. Such an exploratory step may benefit from an approach that does not take for granted a uniform–universal expression and conceptualization of moods, especially not the Western-Caucasian perception, and allows for culturally-sensitive expressions of individual symptoms and complaints as well as their clustering into syndromes and diagnostic entities. Furthermore, perception of order and disorder, the boundaries of accepted "normalcy" and the definitions of abnormal behaviors vary among cultures and do not always fit into the current biomedical Western-world view.

Therefore, establishing a diagnosis of a mental disorder such as depression in different cultures poses a challenge (Manson, 1995; Alarcon et al., 1999). For example, negative answers on the first DSM-based CIDI pivotal questions, may not be taken at face value and may lead to spurious reports. It is suggested that prior to cross-cultural harmonization efforts, an additional insight into culture specific constructs is needed. To address this issue we carried out descriptive quantitative study aimed towards the assessment of phenomena and constructs of depressions and anxieties in women in several cultures.

2. Methods

In preparation for a series of round tables and workshops on cross-cultural diversity of the phenomenology of depressions and anxieties in women, invited