



Literature Review

Cultural Influence on Clinical Features of Depression

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ABSTRACT

Introduction: Depression is a common cause of poor health throughout the world. Genotype factors and cultural environment will interact to influence the psychodynamics of a person's behavior in expressing depression. This paper aims to describe the influence of cultural factors on a person's psychodynamics and clinical features of depression. **Methods:** PubMed and Google Scholar were searched using the following keyword (depression) AND (clinical features OR clinical appearance) AND (psychodynamic) AND (cultural influences) using the journal publication filter for the 2014-2020 issues. We also used textbooks published in the last 10 years and were related to writing themes. **Results:** Every individual has "internal" and "external" views within him, which are influenced by the culture in which he grows and develops. These views, along with beliefs, religions, and gender differences can influence the type and severity of depression as well as variations in clinical appearance. In addition, most of the existing psychometrics developed in Europe and the United States, so some items are not appropriate when applied in different cultures. In Indonesia, there is an Indonesian Depression Checklist that has been adapted to Indonesian culture to detect depression. Physicians must avoid stereotyping members of certain cultural groups while respecting the importance of cultural influences. **Conclusions:** Psychodynamics and culture will influence behavior in response to the distress, resulting in clinical vary features of depression across cultures. Healthcare workers must have the cultural competence to sharpen their analytical power and avoid misdiagnosis of depression.

INTRODUCTION

Depression is a common cause of health problems worldwide and according to the World Health Organization (WHO) was the fourth most common disease in the world in 2000. The diagnosis of depression is mainly based on symptoms and there are no objective tests. Verbal and nonverbal communication is a central element in doctor-patient interaction where nonverbal communication patterns vary between countries [1]. This can be a problem if the doctor accepts patients from a different culture than himself. Depressive symptoms can be overlooked when the patient presents with somatic (physical) symptoms [2]. The prevalence rates of depression vary across countries, with quite large differences, from 1.6% in Japan to 26.3% in Chile. Data generated from the WHO survey may differ from data from other surveys by such a large difference that the prevalence of depression in different countries is difficult to adequately compare. This variation in prevalence can be caused by several factors, including population selection, sample inclusion and exclusion criteria, sample size, and mean age of the sample. Moreover, the various screening and assessment tools used to collect data are not the same, and some of them cannot be applied across cultures [3]. Genotype factors and cultural environment will interact to influence the psychodynamics of a person's behavior in expressing depression. Clinicians need to have "cultural competence" so that they can diagnose depression and use psychometrics appropriately. It is difficult to diagnose depression correctly due to cultural differences. If the assessment does not pay attention to socio-cultural factors, the possibility of misdiagnosis will increase [3]. This paper aims to describe the influence of cultural factors on a person's psychodynamics and clinical appearance of depression.

REVIEW

Psychodynamics of Depressive Expression: Focus on Cultural Influences

The patterns and standards of a person's life history are first and foremost things that are traditionally passed down in his community. Since birth, the individual's genotype will interact with the environment (habit) where he was born and develop to provide experiences and shape his behavior. The cultural environment in which he grows and develops will "communicate" how to think, feel and behave, and his genotype will affect how the individual expresses his behavior especially in dealing with stress [4, 5].

Until now, only a handful of studies have addressed the neurobiological factors of culture's influence on depression. A study conducted by Dressler et al. in 2016 it was hypothesized that cultural consonants in family life would be a mediator between genotype factors and difficulties experienced in childhood. The interaction between childhood adversity and polymorphisms at the 2A serotonin receptor is associated with more severe depressive symptoms. Specific genotypes of individuals (i.e., serotonin transporters, serotonin 2A receptors, dopamine D2 receptors, and brain-derived neurotrophic factors) can result in differences in the sensation of "experiencing" even when exposed to events in the same environment, and in turn, result in differences in express depressive symptoms. Further analysis showed that cultural fit in family life will be a mediator for genes and the environment, and the effect will be more pronounced in the lower social environment. This study strengthens the role of the serotonergic system in learning, memory, and regulation of responses to stress, as well as how these processes will ultimately interact with environmental events and circumstances [5]. The inflammatory process is also associated with specific symptoms of depression, namely interleukin 6 (IL-6) which is associated with diurnal mood variations, sleep disturbances, difficulty concentrating, and fatigue [6].

From recent findings, it is stated that there is a reciprocal relationship between

cognitive function and depression, namely cognitive dysfunction can be a risk factor for depression and depression can interfere with cognitive function [7,8]. Trauma in childhood can affect the cognitive function of depressed patients [9]. Owned cognitive function and culture will be the basis of mimesis (imitation) which is the first level in

communication and a pioneer in symbolic linguistic systems [10]. Thus, the developmental stage used in this paper the Piaget's theory of cognitive development as seen in table 1, although it can also be explained through other developmental theories such as Erik Erikson's theory of psychosocial development.

Table 1. Psychodynamic of Depression Based on Piaget's Theory of Cognitive Development

Stages	Psychodynamic
Sensorimotor (birth – 2 y. o.)	<ul style="list-style-type: none"> - Learn through sensory observation, and gain motor control through environmental activity, exploration, and manipulation. - Communication is carried out with mimesis (imitating) → the critical embryo of a truly symbolic linguistic system. - The first level of culture: the practice of mimesis, artifacts, and interactions with social figures in their lives in routine events and activities. - The habits in a culture that are applied in daily activities will enter into the procedural memory (e.g.crawling, standing, spoon feeding, and so on). - These activities are mimetic content of their social experiences. - At The end of the 1st year: begin to participate more actively in a socioculturalral environment through movement (e.g.pointing), play, and other means[10,11].
Preoperational (2 – 7 y. o.)	<ul style="list-style-type: none"> - The activity of thinking and considering is still at an intuitive level and not able to think logically or deductively. - Not being able to face moral dilemmas, even though they already have feelings about what is good and what is bad. - Have started to have language functions, mental images, and symbolic signs, and are egocentric. - Spoken language began to be used to interact with the social environment, including cultural messages which were also conveyed verbally to children. - A critical period in the memory development record: procedural declarative memory. - Certain cultural habits and behaviors in which the individual grows and develops will be stored in his procedural memory and carried on throughout his life. - All of this memory will affect the cognitive aspects and form the autobiographical memory of the individual which later determines how the individual expresses his emotions (including expressions of depression)[10], [12]. - Begin to gain "self-awareness" and can resist changes in their routine. - Individualist culture: parenting tends to use acceptance/independence which in turn will make the child have high self-confidence[10].

- Collectivist culture: (= traditional value) parenting tends to use acceptance/dependence, which leads to conformity. They more often adjust to authority in groups, such as parents, rather than individualists[12,13].

Children and adolescents enjoy healthy development and positive adjustment when there is sufficient deep parent-child closeness and warmth together with adequate parental autonomy. Too much parental control, conflict, and support are not consistently correlated with depressive symptoms[14].

Concrete operational (7 – 11 y. o.)	<ul style="list-style-type: none"> - Act and work in the world of things and events that are concrete, real and understandable. - Begin to pay attention and cope with various information outside of themselves → can see things from another person's point of view. - Able to consider and follow rules and regulations, and can organize themselves, and begin to develop a feeling of moral and regulatory values[15]. - The "internal" and "external" views begin to emerge which will be taken into consideration for their actions, including when they experience depression. - These "internal" and "external" views will also determine how a person expresses his emotions (e.g.depression)[15].
Formal operational (11 y. o. – end of adolescence)	<ul style="list-style-type: none"> - Children can think abstractly, consider deductively, define concepts, and have the skills to face various possibilities and combinations so that they can grasp the concept of possibility. - Adolescents seek to overcome all possible relationships and hypotheses to explain data and events. - Language usage is complex, follows formal rules of logic, and is grammatically correct. - Abstract thinking is shown by the interest of adolescents in various philosophical, religious, ethical, and political issues. - Vulnerable to self-conscious behavior[16]. - Guilt (ethical feeling) begins to emerge from not meeting ethical challenges and the presence of biological, sociocultural, religious, and situational influences → arises from a challenge to an individual's values or culture → one's conscience is activated, and one begins to take personal responsibility. - The inability to comply with one's moral standards causes guilt, whereas the inability to comply with another's significant moral standards results in shame. - Guilt and shame act as "behavioral sensors" → in the face of stressful life events associated with a diagnosis of depression[14,16].

A person's background will form the basis for many ideologies that are preserved for his life. The development of structures in childhood plays an important role in determining feelings and behavior throughout life and in responding to changing socio-cultural conditions. Early childhood development relies heavily on socio-cultural supports such as basic cognitive structures and inherent constructive processes

[10, 15].

The Influence of Culture on Different Expressions of Depression

Culture is a set of values, attitudes, beliefs, and expectations shared by a group of people [17]. Culture can be conceptualized as a specific social identity that includes characteristics that define a group [18]. Culture will influence behavior in response

to distress. For example, someone will tend to show symptoms that can be accepted and understood by the community [17]. One's cultural environment, through positive and negative sanctions, helps shape the ways a person experiences and expresses emotions, including depression [19].

Culture is often distinguished from individualist culture and collectivist culture. Individualist culture, as shown in many societies in America and Europe, emphasizes the value of personal freedom and tends to place personal goals above group goals. On the other hand, collectivist cultures, such as those in Asia, Africa, and South America, emphasize social harmony and tend to sacrifice personal goals for group or family goals. In individualist societies, a person is encouraged for autonomy, independence, self-assertion, and a sense of self-agency. Whereas in a collectivist society, a person is encouraged to respect authority, have a sense of social responsibility or a sense of social attachment, and be in harmony with their environment [13, 20, 21].

Depression can be presented with psychological symptoms as well as somatic symptoms that are influenced by cultural variations in individuals. In individualist cultures, there is a tendency to "psychologically" depressive symptoms, with a focus on reporting psychological symptoms (e. g., sad), or cognitive symptoms (e. g., excessive guilt). They have an unusual emphasis on personal experience and interpersonal emotional communication. Internal focus is more emphasized than external focus. Depression is caused by factors related to the individual. For them, depression is a mental health challenge, so they tend to seek help for depression symptoms and be treated appropriately at the individual level. They also tend to discuss functional problems experienced by depression, such as problems with social function (social isolation), body, health, and biology (death and self-destruction). They will allow the cognitive, emotional, and social experiences of depression to become clearer [22, 23].

Collectivist cultures are more likely to report somatic symptoms to indicate psychological distress, especially in an environment where the stigma against mental disorders is strong. Somatic symptoms are more socially acceptable than depressive symptoms. By only reporting somatic symptoms the depressed person will be able to play the role of the sick person without being stigmatized. This culture is prevalent in Asia and the Middle East. They will see depression as a family/community problem, not a personal one, and perceive group involvement as the best treatment. Social factors are considered to be the main contributors to disease. The more non-Western cultures there are, the more somatization will occur. The risk of developing depression can increase when someone who comes from a collectivist culture, lives in a society with an individualist culture, and vice versa. Many obstacles arise when it comes to health centers due to communication problems due to cultural differences, as well as cultural competencies that are not owned by personnel in health services [1, 18, 20, 23].

The language of emotions and suffering presents challenges when trying to understand depression. We will not find the term "depression" in some languages, for example, in indigenous Australians and Americans, as well as in parts of Southeast Asia. In 1986, Brandt and Boucher conducted research in Indonesia to find local idioms in Javanese areas that were used to express depression. From this study, 13 terms to describe depression were obtained, namely: kalah (lost), apes (bad luck/misfortune), putus harapan (hopeless), hina (degraded), merana (misery), kehilangan pegangan (lost), malang (bad luck / unlucky), pesimis (pessimistic), nelangsa (sadness/self-pity), patah semangat (discouraged), putus asa (hopeless), sia-sia (useless), and sial (bad luck / unhappy) [3]. In the Special Region of Yogyakarta, depression can present with physical complaints such as headaches (sirahe cenat cenut), burning in the

chest (dodo rasane kemranyas), the tension in the neck (githoke pating creneng), and stomach ache (wetenge rasane mbeseseg), all of which recognized by doctors as an idiom for psychological distress [24].

Enforcement of Depression Diagnosis Due to Cultural Differences

In evaluating individual health, there is sometimes a conflict between the “internal” views of the patient and the “external” views of the health care provider. The patient can consider the symptoms they are experiencing to be normal, but in the view of the health care provider, they need to be treated. This will be a challenge in itself [15]. For cases of depression, the difficulty of diagnosis is mainly due to cultural differences that can present different clinical features of depression. The clinical features of depression will be greatly influenced by the environment in which he grows and develops and in which region when he experiences the depression. A patient may perceive anxiety, depression, or other forms of mental illness as “normal” because of his circumstances and environment so he may not acknowledge the severity of his symptoms and ultimately not seek help [15]. The difficulties will become more pronounced when the patient and therapist come from different cultures.

Religions and beliefs can also influence the type and severity of depression. Religiosity has a buffering effect on the relationship between stressful life events and depressive symptoms so the better the level of religiosity, the better the relevance will be [25, 26]. In addition, gender differences also affect the level of vulnerability. Girls tend to experience higher rates of depression than boys because girls tend to ruminate, and think over the causes of stress, and this continues into adulthood [14, 25]. For this reason, anamnesis must be done properly and completely to get a complete picture of the patient’s background so that there is no misdiagnosis for depression.

The stigma becomes a barrier for some-

one to seek help when experiencing depression. Mental health-related stigma appears as a negative attitude due to prejudice or misinformation. This will affect a person’s perception of mood disorders and their behavior in seeking help. This stigma prevents people with depression from seeking help. They feel embarrassed and choose to suppress their feelings. The higher the level of self-stigma, the greater the negative attitude toward mental health care. The stigma surrounding depression varies between cultures. For example, schizophrenia is more acceptable among Balinese than depression. They will be negative towards people who suffer from depression because in their belief, the possibility of experiencing depression is small and when it occurs, they are pessimistic that depression can improve. In Japan, the level of stigma against depression and schizophrenia is equally high, although depression is at slightly lower levels than schizophrenia. Black Americans with depression will be labeled “crazy” and “weak,”. Likewise in Korea and Russia, there is a belief that depressed people are “weak” [3, 27, 28].

From the above description, it can be seen that the clinical manifestations of depression can vary between cultures and there are several local idioms used to express depression so culturally adapted psychometrics are needed to screen for depression. Most of the existing psychometrics were developed in the United States and Europe, so some items are not suitable for application in other countries with different cultures [3]. For example, the item “loss of sexual interest or pleasure” is an indicator of depression in Western countries, because sex is widely discussed. However, in non-Western countries, talking about sex is taboo, so individuals in these countries may not give an honest answer to the item. Therefore, the item “loss of sexual interest or pleasure” is not a good indicator of depression in non-Western countries [14]. Psychometry needs to be used with caution, especially in interpreting the results,

and should be adjusted to the socio-cultural background of the patient. In Indonesia, there is a psychometric Indonesian Depression Checklist (IDC) that has been adapted to Indonesian culture to detect depression. This psychometry consists of 19 items covering 5 parts, namely physical symptoms, affection, cognition, involvement in social activities, and religious activities [3].

Culture is strong and dynamic in shaping depression expression. However, a doctor should avoid stereotyping members of certain cultural groups while still paying attention to the importance of cultural influences [18]. It is very important to evaluate any physical, psychological, and social barriers that may prevent a person from seeking treatment. Reducing these barriers, it can reduce the number of untreated mental disorders, and ultimately improve the mental well-being of society. This allows people to live more positive lives [15]. There is certainly no single approach to providing appropriate healthcare for all cultural communities. It is necessary to understand the extent to which the program of health services to be provided makes sense, both in structure, and practice and in its meaning for the community [29, 30]. Thus, health workers need to have the cultural competence to sharpen their analytical power.

Cultural competence is the ability of individuals or organizations to interact effectively with people from cultures other than their own. With this competency, healthcare providers can effectively provide health services that meet the social, cultural, and linguistic needs of patients. Cultural competence includes “linguistic competence” (the ability to provide spoken and written language services according to culture), “translation” (communication in written format), and “interpretation” (verbal communication) [29, 31]. With their cultural competence, service providers can make correct diagnoses and provide therapy services that are tailored to the patient’s culture. Methods for providing culturally

competent care may include bicultural/bilingual staff, trained medical interpreters, and qualified translators. When treating patients, language skills play an important role. Language barriers in communication significantly impair the safety and quality of care, which can lead to misdiagnosis, medication errors, and non-adherence to medication, among others. It is impossible to do psychotherapy without the ability to communicate effectively [31].

CONCLUSION

The variety of clinical features of depression which is influenced by the psychodynamics of the person in several countries makes it difficult to diagnose depression. A person’s background will form the basis for many ideologies that are preserved for his life. Culture will influence behavior in response to distress. Every individual has “internal” views and “external” views within him that are influenced by the culture in which he grows and develops. These views, along with beliefs, religions, and gender differences can influence the type and severity of depression as well as variations in clinical appearance. In individualist cultures, there is a tendency to ‘psychologically’ depressive symptoms, with a focus on reporting psychological symptoms, or cognitive symptoms. Whereas collectivist cultures are more likely to report somatic symptoms to show psychological distress, especially in a context where mental illness is highly stigmatized in its area.

The existence of stigma and certain beliefs in an individual can prevent the individual from seeking help when experiencing depression. In addition, most of the psychometrics currently available were developed in the United States and Europe, so some items are not appropriate when applied in other parts of the country with different cultures. Psychometry needs to be used with caution, especially in interpreting the results, and should be adjusted to the socio-cultural background of the patient. For this reason, the anamnesis must

be done properly and completely to get a complete picture of the patient's background so that there is no misdiagnosis for depression. Thus, health workers need to have the cultural competence to sharpen their analytical power and avoid misdiagnosis of depression.

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Conflict of Interest

We have no conflict of interest to declare.

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