



CLINICAL PRACTICE

Cross-cultural aspects of depression in general practice

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It was previously thought that black Africans from traditional cultures rarely suffered from what in the West is classified as depression. The word 'fatalistic' was often used to describe what was assumed to be a lack of emotion or feeling. It is being increasingly discovered by psychological and psychological research that depression in black Africans is underdiagnosed as it presents in different ways of living and interacting as well as from a different existential dimension and world view.

From a constellation of symptoms and signs, the West has developed a concept and label of depression that fits and suits Western culture. Traditional African culture has not concretised or labelled this concept yet so that it remains diffuse and undifferentiated. It may present with different linguistic phrases, metaphors of life and symbolic language and often as a story that attempts to express the complex realities of life.

An exploration into these stories (and other mediums such as song, theatre, poetry and literature) may reveal that depression is as common among black Africans as it is in the West, but that it is unrecognised and underdiagnosed.

How does one diagnose depression in a Zulu patient who comes down from the villages of Hlatikhulu or Ntabamhlophe in the mountains, or from Msinga and Nkandla in the low bushveld? It is a meeting between two worlds of different experience, meaning, language and culture.

The patient works within the experience of his or her social and cultural life whereas the doctor works within the criteria laid down by the *Diagnostic and Statistical Manual-IV (DSM-IV)*¹ and has a list of symptoms that have to be fulfilled before the diagnosis can be made. These symptoms and references are derived from both a biomedical perspective and the doctor's own experience of living in the Western world. The doctor's language and even grammar are technologically based. We have now classified almost every activity that human beings are capable of and are busy with subsets and smaller boxes, into which human behaviour can be fitted. When we encounter a traditional African culture that is not informed in this way and that experiences illness differently, we are often at a loss as

how to assess, diagnose and treat such patients.

For instance, traditional rural Africans may not differentiate their cognitive functions from their bodily functions and symptoms. Their dreams, visions, feelings and inner thoughts are not separated from their bodily symptoms of illness. There is no dichotomy between the spirit or soul and the body.²

Western psychiatry over the last two centuries of scientific discussion, logical argument, pattern recognition and empirical observation has grouped certain constellations of symptoms and experiences into diagnoses or labels such as depression. Traditional people on the other hand may not experience these conditions in such a delineated and categorised way. Their experiences are more open and connected to the world around them. They are connected to the world via relationships with their families and significant others as well as with the environment, nature and with relatives who have recently died.

How, as a doctor, do you convey the concept of depression to such a people, and how, conversely, do they express their symptoms when they may not have the concept or the language available in their culture? The cultural journey appears to start from a constellation of experiences that are recognised as forming some type of cohesive entity, which is then labelled and can then be communicated.³

This is not necessarily a cross-cultural problem as this form of communication and its difficulties are common to the human race and all cultures; however, it is highlighted and emphasised when two very disparate cultures meet.⁴

Level of direct translation

Partly because of time constraints, most of us function in our practices at the level of literal or direct translation. The words used by patients are taken to represent the 'real' world (called the realist view).⁵ I am going to use English-Zulu cross-cultural interactions as my examples as I am an English immigrant doctor working with Zulus. In Zulu there are, in fact, words that might approximate to the idea of depression. *Dangala* means to be dejected or worn out of body and mind. *Khathele/ukukhathala* in Zulu is used more to convey fatigue but also often carries a sense of worry, while *ukukhathazeka* in Zulu and Xhosa conveys upset, hurt, heartsore, sadness, grief or worry. The plurality of translation of these words emphasises the importance of context in connection with the way many mental conditions are experienced and expressed. In this way illness

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cannot be separated from context or the socially and linguistically mediated nature of human illness (called the material-discursive approach).⁶ Likewise, depression often cannot be isolated from other co-morbid conditions such as anxiety or alcohol and substance abuse.⁷

The Western world also tends to view or objectify conditions as being more static than in the traditional world view, which appears to experience the world more in a state of natural evolution and change. For instance, expressing one's feelings as *ukulangazelelela ukwenza into ethize* means literally 'to crave to do some things' and expresses an inability to settle down, of not being able to relax until you have done something that is worrying you, or a feeling of incompleteness. *Ingcindezi* describes a condition when the patient cannot think or concentrate properly when required to do so. This person is more likely to have sleepless nights and his/her mind is preoccupied.⁸

I have given the above as examples of the typical way that a Western mind like mine searches for equivalent concepts. There is a literal translation followed by a neat package or label. Unfortunately the maps of one culture may not fit the territory of another and one often does not progress past the Western diagnosis or label. The Cultural Hermeneutic Model of medical practice⁹ describes a meaning-centred approach in which one goes beyond the medical diagnosis to interpret the meaning, experience and explanations of the causes of the diseases as held by the patients.

Traditional African presentation of depression

The presentation of depression may be divided, in a necessarily artificial way, into four main forms. This is from the perspective of a general practitioner and pertains to the primary care profile encountered by a generalist and not the profile of patients referred to a psychiatrist.

Somatic complaints

Firstly, depression often presents as some form of bodily complaint. The patient expresses an embodied experience of human illness,¹⁰ speaking with his or her body. Pain may be expressed as headache/*ikhanda*, backache/*iqolo*, stomach ache/*isisu*, chest pain/*isifuba* or whole-body pain/*wonke umzimba*. These are messages from the patient, or what Michael Balint called 'offers'¹¹ or others have called 'patient requests'.¹² They are acceptable carriers of existential pain in the society of both the sufferer and the Western doctor. In family medicine they have been called Entry Ticket symptoms¹³ if they are used at the beginning of a consultation, and Door Handle symptoms if they are used at the end of a consultation, when the patient is about to open the door and leave.

Wittgenstein concluded that statements about pain were not necessarily intended as descriptions of internal sensations but

were social messages that needed attention at a different level than the biological.¹⁴

Fatigue variants

After some form of pain, and probably of equal frequency and importance, is the symptom of some form of fatigue/*ukukhathala*, loss of energy/*ukuphela amandla* or tiredness/*ukukhandleka*, which can also mean suffering from an illness for a long time.

Messages of distress

Thirdly is a miscellaneous group of symptoms that are almost infinite and often individual such as dizziness/*isiyezi*, loss of appetite/*inhliziyi imnyama*, and sleeplessness/*ukuqwasha*. This is no different from Western patients and is often interwoven with anxiety as a co-morbid condition. Two general symptoms, which may be sensitive markers of anxiety-depressive states, are irritability/*ucasuka kalula*, or to be irritated by a slight noise/*casulwa umsindo omncane*, and disturbed sleeping patterns/*abufika ubuthongo*. A useful open question in these cases is 'when you are unable to sleep, what do you think about?'

Some generalised complaints in all cultures come like subtle waves across the consulting room desk, such as 'I'm not feeling myself' or 'I'm just not feeling well'. Similarly in Zulu *angiwuzwa umzimba* literally means 'I cannot feel (zwa) my body'. It can be a metaphor indicating that one is out of touch with one's body and perhaps the real world as well. The patient conveys the uncertainty of not knowing what s/he is suffering from, which may add to or exacerbate the condition. This may also take the form of other general statements such as 'I am suffering badly' / *ngiphatheke kabi* or more specific statements such as 'I am thinking a lot' / *ngicabanga kakhulu*.

Problematic relationships

The fourth presentation of depression in this artificial overview, involves descriptions or stories given by the patient of problems with relationships at home and at work and with life events that have happened to them. The presentations may be expressions of distress that may represent socio-cultural conflict, which cannot be addressed within the biomedical framework of diagnosis and treatment.^{10,15} They are often told in the form of a story or narrative (called narrative-based medicine).¹⁶ Carl Jung felt that diagnosis helped the doctor but for the patient the crucial thing was the story.¹⁷ Stories particularise patients' experience of illness within their local and personal worlds. The experience of the suffering is fashioned in the telling of it. I often find the word 'since' leads into a story of a turning point in a patient's life such as 'since my husband died. . .', 'since the accident. . .'. Another word cue can be 'battle' or 'battling' in which the story is told as a fight, with depression or illness as the enemy. Many doctors are



unable to listen to these stories because of time constraints and are more focused on the search for diagnosis and treatment.

All cultures, in fact, can present depression in a variety of the above categories but the presentation in more traditional societies is more likely to be delivered metaphorically or symbolically as idioms of distress, linguistic images, metaphors or associative phrases. The challenge is the interpretive process (called hermeneutics)¹⁸ to gain an understanding of the world of the patient and how the individual is experiencing his or her illnesses.

Symbolic language

Traditional Africans usually worry from the heart rather than from the mind, and Zulus have some beautiful metaphors such as *inhliziyo ishona phansi*, which means the heart dies or sinks down, and *inhliziyo iyakhathala*, the heart is tired. When they speak symbolically they may refer to blood, *igazi*, as in *igazi seliphelile*, the blood is finished. In the same way the word *umoya* may be used to express either breath, as in shortness of breath, or as a symbol or metaphor for one's spirit or soul.²

Barriers to communication

Many invisible barriers exist between what I have been referring to as the traditional African patient and the Western doctor. These are, among others, status, education, and poverty. Gender is also a factor. Women often do not have the words, or do not have access to the words when speaking to a male or in male company. It is the silence of powerlessness. There is also the tradition of *ukuhlonipha*, which broadly means respect and involves deliberately using alternative words as a gesture of respect. This custom often requires that the woman does not make direct eye contact with someone of supposedly superior status, and the downward look of the eyes may be erroneously interpreted by the doctor as a non-verbal message of depression.

This is just one contextual text illustrating that language is only one of the ways in which depression is expressed. There are also vocal cues that can be, almost subconsciously, picked up along with the verbal content, such as rate of speech, downward inflection of the voice and hesitations in the speech. Intuitively one may pick up that body movements, including eye movements, have slowed down, which Kafka described as a 'shy, evasive, glassy-eyed manner of speech'.¹⁹ There is also non-verbal communication, e.g. facial expressions, body posture and hand gestures. 'The gestures of the hands', said Wittgenstein, 'are organs of language'.²⁰ Some studies appear to indicate that guilt seems to be a less common feature of depression in Africa and is experienced in a different way.¹⁰ It is an extremely difficult mood or thought process to define but it is often interwoven with depression in the Western world.

Dual consultations

Another interesting feature of African mental disorders in general is dual or multiple consultations with other agencies such as family members (usually the senior grandmother), and, among others, traditional healers and faith healers, who are consulted before the medical doctor. The pathways that patients pick and choose in their health-seeking behaviour are called patterns of resort.²¹ Traditional healers are either cast by the West in the role of charlatans, or conversely are over-romanticised as being more in touch with nature and the feelings of their clients. Many traditional healers have a calling/*ukuthwasa* and help in the caring and healing process of the whole person, addressing the condition and also restoring balance by addressing the alleged causes of the illness.²² Others are charlatans who produce diagnoses like magicians pulling rabbits out of a hat and may confirm and thereby exacerbate bewitchment without providing support.¹⁰ Herbal medicines may also cause damage in the form of hepatic and renal toxicity. The medical profession is not blameless in this regard either, but has the benefit of legislated governing bodies and accountability to elected councils.

Search for causation

Another dimension in the diagnosis of depression is that it is not recognised by the patient as an illness or disease *per se*, but as a disturbance caused by breaking a taboo or displeasing an ancestor, or due to a spell that has been cast on the patient. This is not a specifically traditional African trait as all patients in all cultures seek to know the reason why they are ill.²³ Western patients rely mainly on answers from technological medicine whereas more traditional cultures seek divination from a healer, who can restore the equilibrium of their lives. In this context traditional Africa has many explanatory models for mental illness called *ukufa kwabantu*, which broadly means 'the illnesses of the people'.²⁴ The *DSM-IV* uses the term Culture Bound Syndrome for these conditions, which 'denotes recurrent, locality-specific patterns of aberrant behaviour and troubling experience that may or may not be linked to a particular *DSM-IV* diagnostic category'.²⁵

Asking the patient what he thinks is the cause of his condition may reveal one of these categories. Among Zulus illness may be blamed on spirit possession/*indiki/ufufunyane/izizwe*, pollution or contamination/*umnyama*, bewitchment/sorcery/*ubuthakathi*, curses or spells/*ukuphosa* or some form of poisoning/*umkhondo/umeqo/idliso*.^{2,24,26} These labels just touch the surface of a complex cultural heritage that explains the world in different dimensions and from a more mystical, spiritual and cultural view than that of modern medical technology. Nevertheless mental disorders do not necessarily have to have a deeper explanation attached to them, for instance, madness/*ukuhlanya* may be thought of as coming from



bewitchment but is often understood as just happening or somehow coming from the sky.

Conclusion

I have tried in this paper to remain as practical as possible. It is not possible to enter here into the great debates of whether depression is a mood, a symptom or a psychiatric disease. The feeling of being sad or depressed is very common in the general population. Depression has been addressed as a distinct identity, whereas it is usually interwoven with anxiety which appears to present in the traditional African in a more diffuse fashion with fear/*esaba*, apprehensiveness/*ixhala* or 'butterflies in the stomach' metaphors/*ukushaywa uvalo*, which convey fear in the pit of the stomach.

There is also debate as to whether depression is biologically and medically constructed, or socially and culturally constructed. One's culture tells one how to view the world, how to experience it emotionally and how to behave in the world in relationship to other people.¹⁰

There is so much overlap between diagnostic labels in the field of psychiatry that an interesting model was developed by the World Health Organisation focusing on the six commonest conditions, namely depression, anxiety disorders, alcohol use disorders, sleep problems, unexplained somatic complaints and chronic tiredness. This model has been extended for use in South Africa at the undifferentiated level of 'mental problem'⁷ for use in primary health care.

The example of language/culture in this overview has been English-Zulu, yet it appears from research of the literature that the thematic representations are similar in most other southern African cultures, although the metaphors and symbolism may differ. Patients in all cultures speak metaphorically in most consultations and metaphors may even be different in the same language group but in different areas. For instance, *ikhanda liyabanda*, which literally means 'the head is cold', is only used as a representation of headache in parts of northern Zululand.

The West has become so powerful and English so ubiquitous that eventually it will probably be best for the concept and condition of depression to be expressed by the word 'depression' in African languages and cultures. This insertion of an English word, which has no equivalent in an African language, is called 'code mixing'²⁷ and seems inevitable. Many educated black Africans in my practice already present with the words, 'I feel depressed'.

Nevertheless diagnosis and treatment of conditions such as depression will be made easier as we spend more effort

learning about the population we work with. This applies especially to patients' attitudes to disease, their health practices and beliefs, and knowing about the therapists, who are important in their lives. One of the major steps is accepting the above as valid for the patient sitting in front of you.

Together with this acceptance goes an understanding of the many forms in which depression and other mental disorders are presented, especially in the traditional rural areas of Africa.

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