

Depression, the silent killer, a South Asian perspective

Tabinda Bashir
Mohammed Abdul Haseeb

Specialist Family Medicine, PHCC, Qatar

Corresponding author:

Dr Mohammed Abdul Haseeb,
Specialist Family Medicine, PHCC,
Qatar

Email: drhaseeb786@googlemail.com

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Abstract

Depression is a chronic illness having major impact on a significant population of the World. The problem continues to grow rapidly in the wider World. Due to the silent nature of the illness in the vast majority of the people, it continues to be underdiagnosed and untreated.

According to the World Health Organisation (WHO), more than 264 million people are affected by depression Worldwide.

There is no single cause for depression and in a large number of patients, could be multifactorial. The causes can range from bereavement, illness, job loss, divorce or any other stressful factor[1]. In some patients, there may be no trigger associated with depression. Genetics may play a role as depression is known to run in families. There are studies currently underway to link chromosomal abnormalities with depression.

Depression is a leading cause of disability worldwide and is a major contributor to the overall global burden of disease. Depression leads to reduced life expectancy, decreased compliance with treatment for other chronic diseases, poor academic achievement and work performance[2].

More women are affected than men. Close to 800, 000 people die due to suicide every year and suicide is the second leading cause of death in 15-29 year olds. The WHO estimates that between 76% and 85% of people in low- and middle-income countries receive no treatment for their mental health disorder.

Key words: depression, South Asia

Introduction

Grace et al [3] studied the prevalence of depression in 30 countries between 1994 and 2014. They report that South America has the highest aggregate prevalence at 20.6% (95% CI: 13.8–29.7%), followed by Asia at 16.7% (95% CI: 13.5–20.4%), North America at 13.4% (95% CI: 10.6–16.9%), Europe at 11.9% (95% CI: 7.5–18.4%), and Africa at 11.5%. This shows that depression is a major health problem in all parts of the World.

The current Covid 19 pandemic has disproportionately affected the weaker sections of society the hardest. The virus is ruthlessly exposing the gaps between the haves and the have nots both within and between countries. Millions of people risk sliding into poverty and widening the social and economic divisions in the society.

The social isolation due to the pandemic, coupled with the financial costs is likely to cause a severe mental health crisis with patients suffering from anxiety and depression[4].

Depression in South Asians

From our experience of working in Primary Health Care Corporation (PHCC), Qatar with the predominantly South Asian community, we would like to discuss depression in the South Asian population and what steps could be taken to raise awareness of depression in the society and improve access to healthcare for the affected patients.

Depression is a very common problem in South Asians but unfortunately a lot of patients do not recognise its symptoms as related to an underlying mental health disease[5]. Despite the tremendous advances in the management of depression by both medication and counselling, patients remain reluctant to seek help from healthcare professionals. This is true of the South Asian population who live in their home countries as well as those who have migrated to Europe and America[6].

Barriers to seeking healthcare advice for depression

1. Depression and other mental illnesses may be perceived as punishment from God[7]. There may be feelings of deep guilt and shame about the condition. The patient is blamed for the illness and asked to turn to religion to get better.

Religious beliefs can provide support through enhancing acceptance, endurance and resilience. They generate peace, self-confidence, purpose, forgiveness to the individuals own failures, self-giving and positive self-image. A substantial amount of research points to the benefits of faith to mitigate symptoms of depression[8].

Patients may seek counselling from faith healers[9], some of whom may not have good understanding of mental health disorders. While effective coordination between progressive faith-based services and formal healthcare may improve patient outcomes, this coordination is often found to be lacking.

2. Some families associate depression and associated mental health conditions with possession by an evil spirit[10]. The families may seek the help of practitioners of witchcraft who misguide them and stop them from seeking professional advice. This is frequently observed in families from deprived backgrounds with limited education.

3. Patients with depression may see it as a personal weakness or moral failing. They are seen as having brought shame and dishonour to the family generating the kinds of stereotypes, fear and rejection. There is fear of instability and disorder. Families try to hide the condition from others for the fear of being stigmatised. This is particularly the case for unmarried women as families fear that the stigma of depression may prevent them from getting married in the future.

4. Childhood abuse in different forms is widespread in all parts of the world and the South Asian countries are no exception to this. There is a higher incidence of depression in adults who were abused as children[11].

Victims of childhood abuse find it very hard to speak out for different reasons. The perpetrator of the abuse might be a family member and they worry about families breaking apart by speaking out. They may also convince themselves that they will not be believed and be somehow held responsible for the abuse. They may suffer with intense shame and feel that they will lose respect in the society if people find out about the abuse.

5. Women in abusive relationships in marriage may experience increased incidence of depression. They may face social pressure from families to project a picture of harmony and happiness. They may be totally dependent on their husbands for finances and coming out of such marriages can be difficult, leaving them to experience a lifetime of abuse and depressive illness.

6. Evidence demonstrating an association between heavy usage of social media and depression[12] is mounting. While being socially connected to others can ease stress, anxiety, and depression, lacking strong social connections can pose a serious risk to mental and emotional health. Social media use is also linked to feelings of inadequacy and insecurity.

7. Drugs and alcohol excess may also play an important role in people suffering with anxiety, depression and other mental health disorders. This problem appears to be increasing, particularly among the college students in cities.

8. South Asian women may present with somatic symptoms rather than the typical symptoms of depression seen in the Western world[6]. The diagnostic criterion for depression may not be accurate for these population groups and physicians may not link the somatic symptoms with depression.

9. There is an enormous gap in the health and socio-economic conditions between developed and developing countries. This particularly applies to the provision of psychiatric services in a lot of South Asian countries.

According to the World Bank collection of development indicators, 65.57% of the South Asian population lived in rural areas in 2019. The majority of the healthcare providers prefer to live and serve in the urban areas. Patients with physical and mental health problems rely on 'quacks' for their health needs in these places. This coupled with lack of education and false beliefs about mental health disorders renders a significant proportion of the population with no access to adequate psychiatric services.

9. Unlike in the Western countries, most of the South Asian countries do not have a family medicine model of Primary care[13]. The majority of healthcare is delivered by doctors who have completed basic medical graduation and not spent time in structured general practice training.

In the Western countries, most general practice training programmes involve structured curriculum, training doctors in general medicine, general surgery, obstetrics, psychiatry and emergency medicine. Hence General Practitioners as the first point of contact for the patients are well trained to diagnose and treat not only depression but also a lot of other health disorders.

Lack of structured general practice training programmes in South Asian countries is a major impediment to patients getting effective overall health care and in particular mental health services.

Strategies to deal with depression and mental health disorders

A sustained and coordinated effort is needed to counter mental health disorders both at national and international level. This has become a matter of greater urgency in the context of the current Covid-19 pandemic which is leading to a tsunami of mental health disorders in the wider World and particularly in the South Asian countries.

1. Media can play a big role in educating masses about depression and other mental health disorders. Unfortunately, the negative portrayal of people with mental health disorders as violent contributes to stigmatization, stereotyping, discrimination, and social rejection.

Media houses should be encouraged to avail services of psychiatric / medical / scientific advisors instead of mental/medical/scientific advisors. Journalists and producers could undergo short training courses on the mental health disorders so that they can remove prejudice in their reporting and presentations. They should be encouraged to produce movies on mental health disorders to increase awareness of mental health disorders among the masses.

2. There has to be increased funding for health services in general and psychiatric services in particular. The Covid pandemic has laid bare the health gaps in our societies. There has been a severe shortage of healthcare professionals in a lot of South Asian countries to deal with the Covid pandemic. Psychiatric healthcare staff among other specialists, had to be drawn in to deal with the Covid crisis. This led to psychiatric services being severely understaffed, depriving the patients with psychiatric needs of their services.

3. Religious leaders of all faiths and backgrounds need to have basic education about depression and mental health disorders. They should be made aware of local referral pathways for psychiatric services. Faith leaders can play a major role in educating our communities and bring about behavioural changes through their teachings and actions.

4. The General Practice training system similar to the one in the Western countries should be introduced in the South Asian countries. Family physicians should have the basic knowledge and skills to diagnose and treat anxiety and depression and be able to refer to specialists in the more severe cases.

5. There should be greater incentives for healthcare professionals to work in rural areas so that the rural population can access quality healthcare as well.

6. Health centres and clinics should arrange community training programmes and lectures on mental health. More community psychiatric nurses should be trained and recruited.

7. Healthcare professionals should be made aware of atypical presentation of depression in South Asian women as relying on the current diagnostic tools for depression they may under-diagnose the condition.

Conclusion

Depression is a leading cause of disability Worldwide and is underdiagnosed and untreated. The problem is likely to get worse over the next few years as the World faces the after effects of the coronavirus. A sustained effort by Governmental and non-Governmental agencies throughout the World is needed to address this problem with greater urgency. Investment in healthcare and psychiatric services is likely to make the population healthy and better prepared to deal with pandemics and other major upheavals.

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