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Depression in developing countries: lessons from Zimbabwe

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Depression is one of the most important causes of morbidity and disability in developing countries.¹ Zimbabwe, in common with other developing nations, has absolute poverty, economic reform programmes, limited public health services, widespread private and traditional healthcare services, civil unrest, cultural diversity, and sex inequality. We have conducted research on depression in Zimbabwe over the past 15 years, covering ethnographic and epidemiological studies in a range of populations. We compared our findings with research from other developing countries and with evidence from industrialised countries. In the context of developing countries we examined the validity of World Health Organization classifications and medical concepts of depression, the public health implications of depression, and the implications for clinical practice and research.

The validity of Western biomedical models of depression

In Zimbabwe, multiple somatic complaints such as headaches and fatigue are the most common presentations of depression.^{2,3} On inquiry, however, most patients freely admit to cognitive and emotional symptoms.⁴ Many somatic symptoms, especially those related to the heart and the head, are cultural metaphors for fear or grief. Most depressed individuals attribute their symptoms to “thinking too much” (*kufungisisa*), to a supernatural cause, and to social stressors. Our data confirm the view that although depression in developing countries often presents with somatic symptoms, most patients do not attribute their symptoms to a somatic illness and cannot be said to have “pure” somatisation.^{2,5,6} This means that it is vital to understand the culture specific terminology used by patients and to assess mood in those with multiple somatic complaints.

The labels of distress—As in many other languages, there are no direct equivalents in the Zimbabwean Shona language for the terms depression or anxiety.⁷ In the West, these terms are used in everyday language to describe mood changes and by clinicians to denote illnesses. In Zimbabwe, the word “depression” is used almost exclusively to signify an illness, which rarely presents with emotional symptoms. There is therefore an incongruity between the term and its relevance for patients and health workers. As a result, case records that require health workers to state a diagnosis show far lower numbers of depression than is expected from epidemiological studies.⁸ An alternative could be to

Summary points

Depression is common in developing countries, especially in women, with a vicious cycle of poverty, depression, and disability

Depression typically presents with multiple physical symptoms of chronic duration, though simple questions can often elicit psychological symptoms

Anxiety often coexists with depression, and multiple diagnostic categories for common mental disorders have limited validity

Low recognition and treatment of symptoms rather than cause are the hallmarks of current practice in general health care

identify local concepts that may signify depression. Shona models of illness, such as thinking too much (*kufungisisa*) and a belief that supernatural factors had caused the symptoms, have been shown to be closely linked to depression.⁹⁻¹² Similarly, labels such as *shenjing shuairuo* (neurasthenia) in China, *ghabrahat* (anxiety) in India, *pelo y tata* (heart too much) in Botswana, and “nerves” in some Latin American and South African societies are described as local illness categories that overlap with depression.¹³⁻¹⁶

Diagnosis and classification—The WHO self reporting questionnaire was used in studies in Zimbabwe in the 1980s.¹⁷ Subsequently, the 14 item Shona symptom questionnaire (SSQ), written in the local language, was developed.¹⁸ The two questionnaires classified more than 80% of primary care attenders in the same way, suggesting a high degree of agreement.¹⁹ The symptoms represented in the items of the Shona questionnaire were remarkably similar to symptoms in instruments used to measure depression in the West. Analysis of main symptom scores showed that anxiety-depression and panic-phobias were strongly related.² ICD-10 (international classification of diseases, 10th revision) currently categorises depression separately from anxiety. Data from Zimbabwe, however, show that anxiety and depression are strongly associated with each other.² These findings are similar to those from other cultural settings²⁰ and from the recent multinational studies of common mental disorders,²¹ suggest-

ing lack of a clear distinction between depression and generalised anxiety in primary care. Therefore, there is a need to review the validity of categorical diagnoses used in current guidelines (such as ICD-10) and to train health workers to diagnose and treat depression comorbid with anxiety.

The public health relevance of depression

In one study among adults a quarter of people attending primary care and a third attending traditional healer attenders had depression.¹² Up to 40% were still ill at 12 months,²² and the incidence of new episodes was 16%.²³ The one month prevalence of depressive and anxiety disorders was 15.7% in a random sample of women from the community,⁴ and the proportion with postnatal depression was 16%.²⁴ Such high rates of depression, particularly in women, have been reported in several recent studies from other developing countries,²⁵ with some community surveys reporting prevalence rates exceeding 50%.²⁶

Risk factors for depression—In a clinic based case-control study, depression was significantly associated with female sex. After adjustment for age, sex, and clinic site, depression was significantly associated with chronicity of illness (>1 month), number of presenting complaints (≥ 3), lack of cash savings, job loss, and infertility in the previous year.¹¹ Persistence of depression at 12 months was associated with bereavement, higher morbidity scores, psychological illness, and greater disability.²² Among the community sample of women, severe life events were significantly associated with the onset of depression, usually within one month.²⁷ Significant events were marital or other relationship crises, deaths, and events directly related to infertility or to an unwanted pregnancy. Women who had a severe event were less likely to develop depression if they had social support after the event and more likely to become depressed if they had been separated from their mother in childhood for more than a year. Evidence from Western countries is remarkably similar,²⁸ suggesting common mechanisms across cultures for the development of depression. Events involving loss of primary sources of self esteem seem to predict depression in societies in which this has been studied.²⁹ Women in Zimbabwe have a high rate of such events, which may partly explain their high incidence of depression. Evidence from the West suggests that vulnerability to events accumulates—for example, from childhood to adulthood.²⁸

Cycle of poverty, disability, and depression—The relation between depression and change in economic status has been examined in cohorts derived from a clinic based case-control study.^{22 23} Economic stressors, such as having experienced hunger in the past month, were associated with both the onset of new episodes of depression and the persistence of existing episodes. Disability scores (including social, functional, and psychological) were twice as high in subjects with depression throughout the follow up period, independent of economic status.^{11 22 23} Depressed people visit health services frequently and also consult private doctors and traditional medical practitioners. This is associated with high financial costs of health care.^{11 30} Similar findings in other developing countries suggest a vicious cycle of poverty, depression, illness, disability,



Life events and economic stressors are associated with episodes of depression

increased health costs, inadequate health care, and further impoverishment.^{25 26 31}

Implications for clinical management—In Zimbabwe most patients consult both the medical and traditional healthcare systems.^{12 32} Few consult a mental health professional. Primary care providers are usually consulted first, but patients move on to providers of traditional care as the illness becomes chronic. Patients' perceptions of their illnesses and costs are the key factors in the choice between providers. Primary healthcare workers and private general practitioners commonly prescribe non-specific treatments such as analgesics, vitamins, and hypnotics.^{30 32} Recognition of psychiatric morbidity by either traditional healers or medical staff was found to be related to a better outcome.²² In Zimbabwe, this benefit is unlikely to be the result of antidepressant medications as they are rarely prescribed. In industrialised countries, randomised trials of antidepressant and brief psychological treatments in primary care have shown robust improvements in outcome.³³ There are no comparable data from developing countries. There are, however, descriptions of initiatives to train primary care workers³⁴ and pilots showing the effectiveness of brief counselling for survivors of torture³⁵ and of cognitive behaviour therapy for multiple somatic symptoms.³⁶

Conclusions

Depression in Zimbabwe is common, especially in women, and causes considerable disability. Most patients do not receive effective treatment. The symptoms are fairly universal and methods to identify patients with depression that have been developed in

one culture can be used in others, as long as careful attention is given to conceptual translation. Somatic symptoms are the commonest presentations but are not specific for diagnosis. Chronic, multiple symptoms, however, should signal the possibility of depression and should lead to specific inquiry about cognitive and psychological symptoms. Most patients with a mental disorder have a mixture of depressive and anxiety disorder. Dimensional constructs (such as common mental disorders) are more useful in primary care settings than categorical classifications. Culture specific concepts of mental illness, which are similar to the medical model of depression, can be identified and incorporated into the training of health workers. Training guidelines should be based on the clinical problem solving approach rather than the categorical diagnostic approach, therefore the WHO guidelines³⁷ should be modified with these points in mind.

The implications of our study are that, firstly, depression should be included in the general medical training for all levels of health workers and, secondly, health policy in developing countries needs to recognise the considerable public health burden of depression, particularly in marginalised sections of the community. Key health service issues include strengthening of supervision and training for general health staff, putting antidepressants on to the essential drugs lists, limiting the use of medicines that just treat symptoms, and forming referral networks between traditional healers and voluntary organisations. Preventive strategies for depression should include social policies aimed at increasing sex equality, eliminating poverty, and strengthening social support networks for populations at risk. Future research must focus on cost effectiveness studies of treatments for depression and the identification of protective factors that enable people living in deprived circumstances to remain in good mental health.³⁸

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Endpiece

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