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WORLD HEALTH DAY 2017 EDITION



Depression
around
the world

Volunteering and International Psychiatry Special Interest Group to the Royal College of Psychiatry

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Foreword

by Dr Peter Hughes MB BAO BCh FRCPsych, Chair of the Volunteering and International Psychiatry Special Interest Group at the Royal College of Psychiatry



As a mental health community we are proud to mark World Health Day, 7th April 2017, which this year has a theme of depression and suicide.

This is the first time that there has been mental health theme on World Health Day since 2001. We commemorate this day with stories of depression from over 30 countries around the world.

We know that depression is one of the most disabling conditions in global health – currently the third most disabling condition globally and predicted to be the leading and most disabling condition throughout the world by 2030.

Depression is universal, taking no account of class, religion, or ethnic group. It spares neither the rich, nor the poor. It is the silent illness causing untold misery. It leads to effects on whole families, children's health and wellbeing.

In terms of mental health interventions, if there is just one thing we can do, it should be to diagnose and treat depression. Treatment of depression is cost-effective and cheap, with a huge dividend in well-being for the affected and their families.

In these stories we see a range of views of depression, but the same themes come up again and again – barriers to treatment, stigma, missed diagnosis and opportunities to pick up depression are universal in low-, middle- and high-income countries. The countries have been selected through our professional and personal connections and don't represent any agenda. The views expressed belong to the individual authors.

We express our special thanks to all our contributors from around the world for this collaborative collection of stories. Thanks also to Gergana Manolova for coming up with the original idea and to the editors for their effort.

We hope to strengthen the debate about depression, to bring it out in the light and to help those suffering from it everywhere to get the help, information and treatment they deserve.

London, 2017

Mutual Captives

*by Dr Jaspreet Gill, CT1 Psychiatry, Central and North West London NHS
Foundation Trust*

Speak to me, my sadness.
Until when will we be
Prisoners of each other?
I am not the only captive here,
I too have held you
Close inside the coffin of my heart
Because I fear losing the only one
Who understands how empty
This graveyard called life feels.

Depression in Australia



by Danielle Maloney, Acting NSW Statewide Eating Disorders Coordinator, Centre for Eating and Dieting Disorders

We are relatively lucky in Australia, the lucky country as they call it. We have a number of initiatives which address the stigma of mental illness and in particular that address depression, one of the most common mental illnesses. There are organisations like BeyondBlue and the Black Dog Institute which focus on depression and work towards reducing the stigma. There is also the foundation headspace which is focused on Youth Mental Health. With all this in place, rates of depression are still high. Perhaps this is because depression so commonly co-occurs with every other mental illness and with mainly chronic illnesses and injuries.

Investing in depression alone is not enough. It is important also to focus on other serious mental health problems such as anxiety, psychosis, eating disorders and personality disorders, to name a few, and treat them well to prevent the slide into depression.

Depression in Bulgaria



*by Gergana Manolova, MSc Global Mental Health candidate,
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Designated as an upper-middle income country, Bulgaria nevertheless has a long way to go in its mental health services in order to live up to the label. This is most visible in the insidious epidemic of depression, which affects about 15-17% of the population of the country.

The Bulgarians suffering from depression are often the working sick, because sick leave for mental health issues is not well received by demanding employers. An unhelpful and disorganized healthcare system compounds the situation. Doctors are either unable to diagnose mental disorders and offer treatments, referring patients onwards, or else only too willing to prescribe a course of benzodiazepines to 'settle the nerves' and forget about the issue. Diagnostic thinking is mechanistic and patients rarely receive in-depth investigation of their complaints, which may sometimes have an underlying organic cause.

The stigma of visiting the psychiatrist is pervasive, because that officially puts the person into the category of mentally ill. In their view, mentally ill people are permanently excluded from all normal behaviour or enjoyment of life. Self-stigma is often an obstacle to help-seeking.

Unfortunately, there is little understanding in Bulgaria towards people with depression from those around them. People are told to just snap out of it and get on with their lives, and are branded as sensitive and fragile. Often friends would pull back from the sufferers of depression, not comprehending why their personality and behaviour have changed. Without the support network and compassion needed for recovery, many people sink into deeper depression and despair, where they can linger for years.

But people's awareness of mental health issues is growing – with that more people, usually women, start visiting psychologists and psychotherapists, who are in the private sector. Men and women express their depression differently in the Bulgarian culture – men tend to abuse alcohol and show agitated depression, while women show predominantly melancholia. Depression among the elderly, presenting in somatic complaints such as hypertension and bad sleep, is almost never diagnosed, although it is widespread because of their social isolation and often dire financial straits.

Children's well-being receives a little more attention, although there is a severe lack of child mental health specialists in the country. There are new small-scale initiatives to improve detection and treatment in primary health care, which are slowly taking hold.

Depression has festered in the society because of deep social divides, stalled economic growth and oversimplified governance, which all contribute to chronic daily stress and a leaden feeling of hopelessness. Those affected often turn to the only environments that they feel receive them openly, searching for solace and relief – New Age practices, circles for ‘personal growth’,

Neuro-linguistic Programming, holistic healers. Many of these places have a genuine intention to help, but the end result is often patchy and temporary, sometimes detrimental to the relationships and finances of the sufferers. Weak regulation of the mental health sector makes the quality of services rendered by private practitioners uncertain as well.

A strong response to depression everywhere in the world needs to be structural, with improved financing and training of primary care doctors and nurses, campaigns for tackling stigma and promoting good mental health. The work in Bulgaria is just starting now; but hopefully we can turn the tide soon.

Depression in Calcutta, India

The headaches that never go away



by Dr Nandini Chakraborty, Consultant Psychiatrist, Leicestershire Partnership NHS Trust, nandinichakraborty@doctors.org.uk

'Headaches for six months. No physical cause identified. Refer to psychiatry' – a quickly written line on a pink card smaller than a sheet of A4 paper, which formed the records for a patient in a busy state government hospital in Calcutta. The one-line referral from medical outpatients to their psychiatry counterparts formed the bread and butter of our clinical practice.

Emotional pain can come in many forms – headache like a tight band, unresolved back pain, unremitting tummy aches, mysterious joint pains, and unremitting cramps. Bursting pain, pins and needles, 'like electric shocks', twisting, wrenching, heavy... all adjectives that could describe their unhappy lives and the trapped conditions that a population in a developing country could live in when money is tight, a young family needs to be fed, elderly parents need to be looked after; a society where there is no government support for poverty, no benefit system – everyone to themselves.

There were other complaints – indigestion, lack of appetite, sleeplessness, constant tiredness, the lack of motivation to do anything. And always the frustration of something having been missed. "Depression? You mean I am imagining this? The pain that keeps me awake at night? The fact that my stomach cannot keep down anything that I force down my throat? How dare you? Someone has not read my reports right. Can't I have another X-ray?"

When I later trained in psychiatry in a neighbouring state, in Central Institute, it was a standing joke about Bengalis. "Ask a Bengali patient what is wrong and he will take out a thick file," one of my Marathi colleagues said over a sugary cup of tea in the cramped canteen where we exchanged patient stories. "My history starts from 1970 when I attended a marriage party and experienced my first bout of acidity. Since then things have never been right, says my patient, and then it is report after report, investigation after investigation – my heart sinks the moment I see that cardboard folder!" my colleague finishes with a sigh. Indignant though I feel for my community, I must admit that he is right. Depression in Calcutta was physical discomfort – as if raw emotions had vented themselves in raw pain.

Yet there is one woman who stands out in my memory. As I entered the outpatient department that day, she was crouching in a corner, sobbing her heart out on the edge of her faded thin cotton saree. The voices were telling her to kill herself but she

had three children. How could she? “Shock me, madam,” she begged, tears running down her cheeks, her hands very close to clutching my ankles in desperation. “That is the only thing that works,” she cried, referring to electroconvulsive therapy. “Nothing else will take them away”... Somewhere at the root of mental illness the same chemicals run through our nerve endings, just as the same blood runs through our veins.

Depression in China

Depression and *shenjingshuairuo* in China



by Dr Jianan Bao, MSc Global Mental Health candidate, Psychiatry trainee starting August 2017

The evolving perception of depression in China can be understood through historical, cultural and epidemiological perspectives. It is far too complex to sum up in one snapshot, but I will try.

During the Cultural Revolution in the 1960-70s, systematic persecution and humiliation of people considered to be intellectuals and capitalists, often by other citizens through mutual surveillance, led to a state of paranoia and repressed psychological distress. Some have argued that this suffering was expressed through neurasthenia, or *shenjingshuairuo* (神经衰弱), a condition characterised by persistent weakness and fatigue. The prevalence of *shenjingshuairuo* was as high as 1 in 10 in some studies, whereas the prevalence of depression was very low¹. The physical symptoms of this condition were socially sanctioned and less stigmatizing than the symptoms of depression. However, the stigmatization of psychological symptoms is not unique to China and has been described throughout the world. The cultural practices around outward expression of emotions has a role to play as well in creating the condition of *shenjingshuairuo*. Emotions are expressed more indirectly in Chinese culture. The Chinese social psychiatrist Sing Lee gives an example of a Chinese parent communicating affection through cooking a child's favourite food, asking if they are warm enough, or giving them pocket money, rather than direct expressions of affection such as hugging or telling them that they love them². This resonated strongly with myself.

I was born in China but had not lived there for many years. I went to Shanghai for my elective and spent my time at a psychiatric outpatient clinic in a large hospital. I did not see anyone diagnosed with *shenjingshuairuo*. Everyone did however present with a somatic complaint, most often that of insomnia, and nearly everyone left with a prescription, sometimes one for traditional Chinese medications. Perhaps this was due to the lack of confidentiality during the consultations. Sometimes the door would be left open, a long queue of patients standing outside. Most people came with a family member, who would sometimes answer most of the questions asked about the

¹Lee, S. (1999). *Diagnosis postponed: shenjing shuairuo and the transformation of psychiatry in post-mao China*. *Cult Med Psychiatry*, 23(3): p. 349-80; discussion 381-99.

² Kleinman, A. (2011) *Deep China: the moral life of the person: what anthropology and psychiatry tell us about China today*. Berkeley, Calif.; London: University of California Press

patient's mental state in lieu of the patients themselves. It was easier for anyone to talk about somatic symptoms in that setting. No doubt another contributing factor was that doctors' salaries were directly associated with drug sales.

It seems to me unlikely that the symptoms of psychological distress had changed much. It is more likely that the questions asked guided the answers one received. As one psychiatrist in Lee's paper told him, "since we had little understanding of depression in the past, we rarely asked patients about depressed mood"¹. Indeed, the anthropologist-physician Kleinman found that he could elicit symptoms of persistent low mood from patients presenting initially with symptoms of *shenjingshuairuo*, eventually diagnosing 87% of these patients with major depressive episodes². Regardless of how one interprets a patients' symptoms (and, as clinicians, we are always *interpreting* symptoms), depression is a condition of the mind and of the body. The character used for psychotherapy in China is the same as that used to mean heart: 心. Perhaps the mind and the body have always been more connected in Chinese culture.

Depression in Ecuador



by Dr Lucienne Aguirre, Core Trainee Psychiatry (CT3) South West London & St George's Mental Health Trust

The health care system in Ecuador is state funded, through the Ministry of Health. The first line of contact with the health care system is through the primary care physician who is responsible for the implementation of the government's health care policies.

Ecuador is one of the few countries in Latin America that does not have a mental health policy³. In the public sector mental health is focused on psychiatric care. In the primary care sector, 7 out of the 23 provinces from the secondary and tertiary care provide mental health services in general hospitals. Another 7 provinces have psychological care provided by psychologist and only 1 has full psychiatric care at all levels. In total 15 out of 23 provinces in Ecuador have mental health services. Ongoing efforts are focused on strategic implementation of preventative health screening or physical illness, but currently there is no policy for screening for depression and other psychiatric disorders. However, in the last 5 years, there have been some changes in some psychiatric hospitals around the country in the implementation of new mental health policies and pathways for patients. The discharge of very long-stay patients back to the community after many years of being institutionalised is one of the biggest changes in the country.

Depression is one of the most common mental illnesses in Ecuador, followed by anxiety, stress and poly-substance misuse⁴. The stigma around mental health is still a big problem across the country and this can impact the level of support and treatment that people receive. Most of the care is provided in the private sector rather than in the public sector. People may be reluctant to see mental health professionals when experiencing symptoms of depression. This is due to stigma around mental illnesses, lack of resources in mental health, low socioeconomic status and poor education.

'Nervios' (meaning 'nerves' in Spanish), is a powerful word of distress used by Hispanics/Latinos from a variety of Caribbean, Central and South American countries to express concerns about physical distress, turbulent emotional states, and adverse life changes. 'Nervios' is not necessarily pathological but is seen as a natural consequence of the human condition. Depression could be described or experienced in many different ways around the country according to their demographic areas, social

³ Política Nacional de Salud Mental 2014-2024, Version 6.2, Febrero 2014, p. 9

⁴ Política Nacional de Salud Mental 2014-2024, Version 6.2, Febrero 2014, p. 17

background and economic social class. 'Ataque de Nervios' (nervous attack) is one of the most common ways of describing depression, 'sadness' and somatization are also ways of expression when people are in distress.

Depression can be manifested somatically through symptoms such as headaches, gastrointestinal disturbances, or complaints of 'nervios' rather than commonly recognized symptoms. Clinical data suggests that women suffering from depression have a higher prevalence of somatic manifestations than men⁵. An appreciation of cultural manifestations of depression and social factors is necessary to ensure better detection of depression in the public, to assist in formulating psychosocial interventions and the allocation of resources for mental health needs.

⁵ Política Nacional de Salud Mental 2014-2024, Version 6.2, Febrero 2014, p. 18

Depression in England



by Dr Faheem Naqvi, Psychiatrist, Manchester, UK, drfnaqvi@gmail.com

Many cultures lack a substitute term quite as clinical as 'depression'. In England we use it unashamedly often. A consequence of this is that it is extremely common to see patients in outpatient clinics with a presenting complaint of feeling depressed. But it is clear that a quick glance at ICD-10, coupled with a prescription of antidepressants and a diagnosis of clinical depression, however helpful, may not correspond to the whole picture in all cases and can sometimes be damaging.

As a psychiatrist practising in England, it is important to decipher with great care what is meant when a patient uses this emotive and culturally common term. Depression in the English context can relate to both pervasive and non-pervasive low mood. The latter, I would say, is more commonly seen in England and can be as debilitating and risk-prone as pervasive depression. Pervasive and non-pervasive disorders of mood and emotions both need psychological interventions, but the psychological interventions need to be uniquely tailored to the individual.

The first National Health Service (NHS) hospital opened in Manchester, England in 1948. The NHS is the pride of England and employs a staggering 5% of the working population. Unfortunately, a side effect of economic uncertainty, political austerity and mismanagement, coupled with reductions in social care across the board, has seen the NHS stretched to unprecedented levels. As a result patients can struggle to get the appropriate individually tailored psychological therapies that they deserve, which is frankly frustrating.

I started by saying depression is a common English term, but there remains much misunderstanding and stigma despite definite positive strides being taken. Depression is often invisible to the onlooker and so only too often as psychiatrists we hear patients tell us about unsympathetic employers and patients being told to 'snap out of it' or that 'they have everything going for them' by friends and family. Finally, depression can affect anyone and does not discriminate. From my own personal experience, many friends and colleagues that I found the most containing and resilient later went on to suffer from severe depression themselves. Keep fighting!

Depression in Ethiopia



by Dr Jan Klimach, ST4 Psychiatry, Manchester, UK

In November 2015, I was involved in the first week of a new continuing professional development (CPD) programme for primary health care workers in Hossana, Southern Ethiopia, set up as part of the Glan Clwyd Hospital – Hossana Hospital link. The topic discussed at one of the three health centres was depression. Before the session I observed clinics with the Health Officers at this health centre and saw several patients for whom depression was high amongst my differential diagnoses. One which sticks out in my mind was a widowed man in middle age who complained of nonspecific physical symptoms and being off his food. He was managed with injections of Diclofenac and Vitamin B. The Health Officer and I were able to screen this gentleman for mental illness using the ‘Golden Questions’, then take a more thorough history of depression as indicated.

In the teaching session, I asked the Health Officers how many patients they thought they had seen in the last month with depression. The unanimous answer was zero. I showed figures for prevalence of depression in Ethiopia I had found, which were roughly equivalent to other countries. There was a collective shrug of the shoulders and someone said, “It must be in other parts of Ethiopia...”

I returned a year later, mainly to work with medical students and the nursing staff at the psychiatric clinic, but two recently qualified Health Officers requested I attend their health centre to do some teaching on depression. I found they were already knowledgeable and we discussed some patients they had seen whom they suspected had depression. We focussed on distinguishing mild depression – which they could manage themselves – from moderate and severe depression, which could be referred to the clinic at the hospital.

At the clinic, there are two psychiatric nurses who are able to accurately diagnose depression and have access to tricyclics and SSRIs. I saw many patients with depression there managed successfully. However, there are problems. One is that in most consultations, the staff are aware that patients have already been to – or are considering going to – a religious or traditional healer who will inevitably have a treatment to offer. These treatments are not always harmful, and in depression may actually have some benefits, but in effect it creates competition with the nurses. This results in them feeling pressure to prescribe antidepressants when they know they are not necessarily indicated. Another is the costs of medication, and physical monitoring such as ECGs, which are prohibitive for many patients.

A strong reason for optimism, however, is evidence of increasing awareness of

depression and other mental illnesses both amongst the public – attendances at the clinic continue to increase – and among healthcare professionals – as well as the Health Officers mentioned above, staff in other departments at the hospital requested training on mental health topics while I was in Hossana the second time. Both of these factors can only increase the importance attached to depression as a priority illness, and in time, reduce the currently considerable treatment gap that exists in Hossana.

Depression in Ghana



by Dr Konstantinos Tsamakidis, ST5 Psychiatry

The perception of depression is different in Ghana from that in the UK. Most patients seem to be unfamiliar with the fact that depression is a disorder of mental health. They can answer questions about being 'happy' or 'sad', but being 'sad' is not the reason why they come to the outpatient department. The usual presentation is of fatigue and insomnia, and vague somatic symptoms. Sometimes they deny they are depressed, even when symptoms are obvious. I saw a patient who looked depressed, scored his mood as 3/10, was experiencing anhedonia and lack of energy, but would strongly deny there is anything wrong with his mental health and would focus on medical explanation of his somatic symptoms, despite all investigations being normal.

Stigma plays a big role and people don't want to be labelled as suffering with depression or any mental illness. Depressed people tend to be seen as 'weak', unable to enjoy life or do everyday things because they don't try enough. Society thinks they should just get themselves back together, or should pray more. The understanding of the impact and the nature of depression seems rather poor.

Patients do not spontaneously mention suicidal thoughts. They have to be teased out and on a few occasions I was surprised to find out patients experiencing worrying suicidal ideation, since they had already reassured me they had no concerns.

Accidental (due to lack of awareness) or deliberate (due to stigma) minimising of symptoms is frequent. Relatives of patients seem uncomfortable when questions about suicide are asked. Their stress reaction can be to laugh, which in the beginning was very confusing for me. I now realise that this is a way to react to stress, rather than lack of care. Suicide is little spoken about. Even among some mental health professionals here, suicide is thought to be something rare. Yet, in the last 2 weeks in Ghana there have been three suicides of young girls, which have been all over the news: two university students (one hanged herself and one jumped from a height) and one teenage girl. I cannot stop talking about assessing risk in my lectures.

I still bring in my mind the face of a 17 year old boy who was brought to the clinic by his mother because he kept running away from home. The mother could not understand the reason for this and wanted us to 'advise' him. Initially, the boy reported everything being fine. He was smiling nervously, minimising what had been happening. I asked the mother to leave us alone; again he insisted there was nothing wrong. Only after empathic questions and after he trusted me, he became tearful and showed me his diary where he records his daily suicidal thoughts - his

father has been abusing him in horrific ways and his mother is unaware of any of these. He feels sad, worthless and has lost hope. We agreed on a treatment plan and I tried to instil hope. I hope he is doing well.

Depression in Greece



Part 1: The consequences of the economic crisis on the mental health of children and adolescents in Greece

by Dr Christos Terniotis MD, MSc, Child & Adolescent Psychiatrist, Systemic & Family Psychotherapist

2017 marks the 7th year of the ongoing economic crisis in Greece, the worst one the country has known since 1974, when democracy was reinstated. The adult population and especially those who also have a parenting role have to face various psychosocial challenges, which can have a detrimental impact on their well-being. Depression, anxiety and behavioural disturbances seem to be on the rise.

One might wonder: does the financial crisis have an effect on children and adolescents as well? The short answer is it does. Minors are integral parts of the family structure and society, and are not 'exempt' from the consequences of the current situation just because they are too young, or because of parental protection.

Children and adolescents may react to stressful situations in different ways depending on their age. In general, when looking at the children's reactions to stressors, we distinguish two main age groups: the first group includes pre-schoolers all the way through children who are in the latent phase (up to twelve years old); the second group includes adolescents.

Regarding the first group, i.e. the younger children: A child can experience the deterioration in the financial situation of the family as an extremely stressful event. Because of their age, children's understanding of finances is limited and therefore their reactions can be disproportionate to the size of the problem or even to their own parents' reactions. Children of this age group can react to stressful events with attendant insecurity, generalized fears about the future of the family (which they might see as catastrophic), increased attachment to parents and/or increased separation anxiety with impending sense of loss. At school they can present with feelings of indifference during class time and refusing to complete homework. Sometimes they may present with hyperactivity during class time or study. Their school performance might significantly drop.

In the second group (teenagers) depressive symptomatology usually prevails. The lifestyle of adolescents can easily be affected by a deterioration in the family finances, which might for example force the family to cut down on the adolescent's private tuition; (having privately paid extracurricular education is the norm in Greece). The reduced financial resources may also impact negatively on the adolescent's ability to go out with their friends, for example. Depressed teenagers might isolate themselves

in their room for hours. Reduced school performance and social withdrawal can also be seen.

In addition, teenagers can present with behavioural disorders such as oppositional defiant disorder (towards parents and teachers), or more serious behavioural disorders such as conduct disorder (characterized by violent acts, theft, and substance abuse). We already know from research that there is an association between the above disorders and low socioeconomic status; therefore financial challenges can have a negative impact on the adolescents' mental wellbeing.

So, given all the above, should parents inform their children about the family's financial situation? The answer is yes, on two conditions: First, to ensure this is done in a way that is appropriate for the child's age, cognitive and intellectual level, so that the child is not led to false conclusions. Second, to avoid assigning the child roles and responsibilities which do not keep up with their mental and emotional maturity.

Part 2: Depression vs. Depression

by Dr Marianna Siapera, MSc Global Mental Health candidate

While signs of the economic crisis in Greece started showing in 2007, it became more apparent to people in 2009. The first publications on suicide rates in association with the crisis appeared in 2011, claiming that suicides rose by 17% in 2009 from 2007 and unofficial 2010 data quoted in parliament mention a 25% rise compared with 2009⁶. The Minister of Health reported a 40% rise in the first half of 2011 compared with the same period in 2010⁷. A telephone survey showed a 36% increase in the number who reported having attempted suicide in the month before a telephone survey from 24 (1.1%) in 2009 to 34 (1.5%) in 2011 and an increase in suicidal ideation⁸.

In the same period, other studies supported that there was not a real increase in suicide rates as the completed suicide rates, according to the WHO report for Greece, fluctuated between 2.8 and 4.0 per 100,000 between 1960 and 2009. Furthermore, these researchers supported that there were no data to support a causal link between the economic crisis and suicide and reports in the mass media and journals were premature overinterpretations⁹⁻¹¹.

An increase in suicide rates was finally accepted as a fact after data of 2012 were

⁶ Kentikelenis, A., Karanikolos, M., Papanicolas, I., Basu, S., McKee, M., Stuckler, D. (2011) *Health effects of financial crisis: Omens of a Greek tragedy*. *Lancet* 378(9801):1457–8.

⁷ Loverdos, A. (2011) *Response to question by Member of Parliament*. Athens: Ministry of Health and Social Solidarity.

⁸ Economou, M., Madianos, M., Theleritis, C., Peppou, L.E., Stefanis, C.N. (2011) *Increased suicidality amid economic crisis in Greece*. *Lancet [Internet]* 378(9801):1459–60.

⁹ Fountoulakis, K.N., Siamouli, M., Grammatikopoulos, L. a, Koupidis, S. a, Siapera, M., Theodorakis, P.N. (2013) *Economic crisis-related increased suicidality in Greece and Italy: A premature overinterpretation*. *J Epidemiol Community Health [Internet]*.67(4):379–80.

¹⁰ Fountoulakis, K.N., Savopoulos, C., Siamouli, M., Zaggelidou, E., Mageiria, S., Iacovides, A., et al. (2013) *Trends in suicidality amid the economic crisis in Greece*. *Eur Arch Psychiatry Clin Neurosci*.263(5):441–4.

¹¹ World Health Organization.(2009) *Number of suicides by age group and gender, Greece*. 1.

published by the Hellenic Statistical Authority, especially in male adults^{12,13}. However, the debate remains around the ways that the crisis may correlate with the increased suicidality and suicide rates and what interventions would be more appropriate: If the hypothesis that the economic crisis produces increased suicidality in the general population holds true, improving economic indices and taking ‘horizontal’ measures which cover the whole population will be effective for decreasing suicidality. But if the economic crisis affects population vulnerable with mental health problems by decreasing, for example, the health and social provisions, then ‘vertical’ measures are needed targeting this population¹⁴.

The situation became even more complicated when a Greek male pensioner killed himself in the main square of Athens in response to austerity conditions in 2012, leaving a detailed note where he described the political reasons of his decision. Unfortunately, this event received high publicity by the mass media and other suicides followed; researchers mentioned a temporary spike of the suicide rate in males the months following the event that gradually subsided to the initial baseline¹³. Depression has risen from 3.3% in 2008, to 6.8% in 2009, 8.2% in 2011 and 12.3% in 2013 according to a survey; in 2013, in the age group of 35-45 years old, the male adults suffering from depression were slightly more than the women, 16.4% and 14.7% respectively, while in the other age groups the ratio between men and women remained in line with the international literature at 1:2¹⁵.

It is noticeable that all these studies tried to explore the complex phenomenon of suicidality and its association with the crisis by using quantitative approaches and assuming possible causal mechanisms. There is lack of qualitative research on this matters and lack of the perspective of advocacy groups and groups of people who use or have used services. The mental health care system in Greece remains largely hierarchical and psychiatrist-led. Involving all the stakeholders and adopting more participatory approaches is likely the way to move forward in the research, management and prevention planning for complex conditions as depression and suicide in the context of a unique economic and social breakdown.

¹² Papaslanis, T., Kontaxakis, V., Christodoulou, C., Konstantakopoulos, G., Kontaxaki, M.-I., Papadimitriou, G.N. *Suicide in Greece 1992-2012: A time-series analysis*. Int J Soc Psychiatry

¹³ Branas, C.C., Kastanaki, A.E., Michalodimitrakis, M., Tzougas, J., Kranioti, E.F., Theodorakis, P.N., et al. (2015) *The impact of economic austerity and prosperity events on suicide in Greece: a 30-year interrupted time-series analysis*. BMJ Open. 5 (1):e005619.

¹⁴ Fountoulakis, K.N. (2016) *Suicide and the economic situation in Europe: Are we experiencing the development of a “reverse stigma”?* Br J Psychiatry. 209(4):273–4.

¹⁵ Economou, M., Angelopoulos, E., Peppou, L.E., Souliotis, K., Stefanis, C. *Major depression amid financial crisis in Greece: Will unemployment narrow existing gender differences in the prevalence of the disorder in Greece?* Psychiatry Res

Depression in Iceland



by Dr Ferdinand Jonsson, Consultant Psychiatrist

Reykjavík is the most northerly capital city in the world. Icelandic winters are long and dark. Spring and summer are much loved.

The burden of depression is heavy, as it is in many other communities, but hopefully there is a bit more openness about this problem.

A study found the prevalence of Seasonal Affective Disorder to be unexpectedly low in Iceland. It has been suggested that the propensity for SAD may differ due to genetic factors within the Icelandic population.

However, Iceland has had the highest rate of antidepressants prescriptions in a recent OECD study. This is possibly due to the populations beliefs that they are effective. An important factor is that psychological therapies are currently not paid for by the health service. In Iceland, like many other countries, antidepressants are not only prescribed for severe depression, but for milder forms and various anxiety disorders.

Iceland ranks number 35 in a WHO study of country's suicide rates worldwide.

Icelandic society is small and as a consequence it is possible to get to know your fellow countrymen more intimately than some larger communities allow. This is a difficulty around death by suicide. Most Icelanders have an obituary written in the main newspaper, and it is possible to spot the suicide victims.

Suicide statistics are based on official reports and are no more accurate than the record-keeping of an individual country. Hence we are not comparing similar numbers. Iceland is much more likely to give the verdict of suicide than some other countries such as the UK.

Thankfully many heroic individuals have spoken out about their suffering of mental illness. There have also been prevention campaigns directed at young men, with a positive response.

Depression in India



by Ramya Kannan, Head of the Tamil Nadu state bureau for The Hindu and health reporter

For anyone who's been in India, it would be impossible to sidestep the influence of the movie industry. It's pernicious in its reach; the films are a part and parcel of everyday life, the stars – the aspirational ideal. It does not always work out well, this intimate connect between the people and their movies, but sometimes, just sometimes, there are substantial takeaways. Most of India actually heard of depression when Deepika Padukone, a star in her own right, wrote about her experience with that despondency that would not go away, of it having a scientific name: clinical depression.

If we were to set a rough timeline of sorts, count this at the beginning. The awareness of depression as a serious mood disorder entered the social consciousness about the time of Deepika's bold confession. It inspired many to come forward with their own mental health issues, it spurred the recognition of depression among those battling that blue feeling day in and day out, not knowing what was bringing them down. It brought people to psychiatrists' clinics and had them seek treatment for their conditions. After a star confession, even depression is more acceptable. This is a huge step forward, because it has been proved that clinical depression can be life-threatening, and is among the foremost causes of suicide. Everywhere there is an intervention, count that as one life saved, and then, that life made better.

Admittedly there are nooks and crannies in this country where Deepika Padukone or her depression are unheard of. Last year's National Mental Health Survey provided empirical data to establish that one in every 20 people in India suffer from depression¹⁶. Look at the numbers. With a population of 1.3 billion and counting, the actual numbers would be simply mind boggling, or around 65 million. But here's another nugget: According to the WHO, India is one of the most depressed countries in the world with 36% of Indians likely to suffer from major depression at some point in their lives¹⁷.

Are all of them getting treatment? If we had a psychiatrist for every statistic on mental health that has come out, the country might have better mental health indicators. According to a paper on the website of the Royal College of Psychiatrists, there are between 3,500 and 5,000 psychiatrists in India, which translates to one psychiatrist per 200,000 to 300,000 people. Another article pegs the average national deficit of India at an estimated 77%. More than one-third of the population has more

¹⁶ <http://www.thehindu.com/news/cities/bangalore/Survey-One-in-every-20-people-is-depressed/article16081373.ece?homepage=true>

¹⁷ <http://indianexpress.com/article/blogs/with-36-of-india-depressed-we-must-end-taboo-around-mental-health/>

than 90% deficit of psychiatrists¹⁹.

And it is a safe guess to say that those available are also in the urban centres. Except for a few successful attempts at tele-psychiatry to address this mental health care deficit (such as the SCARF programme²⁰, and the one being run by the M .S. Chellamuthu Trust in Madurai²¹), the vast section of the rural population is without significant access to facilities. The District Mental Health Programme (DMHP), wherever it is active, takes care of the towns, still leaving a vast population unreached and untouched.

Some of these populations are so remote from health care that all they can grasp at sometimes are traditional faith healers or charlatan quacks. With the limited experience of that form of 'cure' it is not surprising these people look at modern science with mistrust and caution. Add to that the stigma of a mental health condition, and a psychiatrist becomes a person to run from, even if by chance she or he is running towards you. A key goal of the DMHP is also to address stigma in order to promote health-seeking behaviour.

Indeed, behaviour change communication is not an overnight task. But unless the state marshals its resources to ensure adequate health care facilities and personnel are within the reach of our population, access and the recognition of depression as a mental health issue will remain a pipe dream.

Sadly, one that not even the dream factory and its stars – the Deepika Padukones and Robin Williams of the world – will be able to touch, or change.

¹⁹ Thirunavukarasu, M., Thirunavukarasu, P (2010). *Training and National deficit of psychiatrists in India - A critical analysis*. Indian J Psychiatry [serial online] 52, Suppl S3:83-8. Available from: <http://www.indianjpsychiatry.org/text.asp?2010/52/7/83/69218>

²⁰ <http://www.mhinnovation.net/innovations/scarf-tele-psychiatry-puddukottai-step>

²¹ <http://www.msctrust.org/?s=telemedicine&submit=GO>

Depression in Iran



by Dr Hamid Rahmanian, hamidreza_rahmanian@yahoo.com, Dr Abbas Mohammadiniasab, Dr Roman Duncko

Mental illness is common and it affects one in four people. Depression is the most prevalent mental health disorder. It has been estimated that depression will become the second most common cause of disability by 2020, next to heart disease²².

Research has shown many people who die by suicide have a mental illness and depression is one of the most common causes.

In Iran, like in many other countries, stigma is an obstacle to talk about your emotions. In Iran, many people with mental disorder, especially depression present with somatic symptoms.

The Iranian Mental Health Survey (a nationally representative face-to-face household survey with a multistage, cluster sampling design) was conducted from 2010 to 2011 nationwide on 7,886 people in the age-group of 15 to 64 years²³. The result of the survey is indicating that 12.7% of the general population of Iran are depressed. The prevalence rate of depression was reportedly 15.4% among women and 10.2% among men. The findings of the survey showed that depression affects people with emotional and economic problems more than others. The study also showed that between 22 and 24% of separated couples (both officially and emotionally divorced ones) are depressed.

Couples staying together were reportedly happier, with depression rate standing at 12.5% among them. Depression was more common among unemployed individuals. While only 11% of employed people had depression, 16.5% of the jobless reported feeling chronic sadness. Urban living was associated with a higher risk of depression. The findings showed that 13.5% of urban dwellers and 11% of people living in villages were depressed in Iran. The result showed that depression was also linked to the social class of people. About 14.9% of people from lower social classes and 11.7% of people from upper classes suffered from depression.

The observed association between depression and sociodemographic characteristics including gender, marital status and socioeconomic status were in accordance with findings from similar studies in other countries²⁴. The findings from the Iranian Mental Health Survey also showed that about 60% of depressed people do not seek professional help from a therapist and about one-third prefer self-medication and home remedies. These results indicated that about 77% of people with a mental disorder do not receive

²² Peveler, R., Carson, A., & Rodin, G. (2002). *Depression in medical patients*. *British Medical Journal*, 325(7356), 149

²³ Rahimi-Movaghar, A., Amin-Esmaeili, M., Sharifi, V., Hajebi, A., Radgoodarzi, R., Hefazi, M., & Motevalian, A. (2014). *Iranian Mental Health Survey: Design and Field Proced.* *Iranian Journal of Psychiatry*, 9(2), 96–109.

²⁴ Kessler, R. C., & Bromet, E. J. (2013). *The epidemiology of depression across cultures*. *Annual review of public health*, 34, 119-138.

Depression in Ireland



by Dr Anne Doherty, Consultant Psychiatrist

Rates of depression and patterns of presentation of depressive illnesses in Ireland are similar to those reported in other developed countries, although there have been few epidemiological studies conducted in the population as a whole. However, service provision is patchy and not standardised. Rates of depression as high as 26% have been reported in primary care²⁵, and as high as 52% in vulnerable groups such as the homeless²⁶. The ODIN study reported higher rates in urban regions of Ireland compared to rural regions²⁷.

The configuration of Irish mental health services is loosely based on the policy paper 'Vision for Change'²⁸. Published in 2006, Vfc sets out how the provision of mental health services in Ireland should progress in to the post-institutional care era. General practitioners (GPs) are the 'gatekeepers' to mental health care and treat the majority of patients with depression, referring onwards to community mental health teams (CMHTs) as appropriate.

With respect to the provision of treatment for depression in Ireland, there are no barriers to access to anti-depressant treatments, with any prescribed pharmacotherapy provided free of charge to those eligible for free healthcare. Psychotherapies are less accessible: most CMHTs have two clinical psychologists for a population of 150,000. In the past 5 years, the availability of counselling in primary care has increased, and further counselling and psychotherapy is available via charitable foundations such as Pieta House.

There are significant gaps in service provision for specific groups which have high rates of depression, such as for the homeless, and during the perinatal period. A study by Crotty and Sheehan found rates of depression of 14.4% in the perinatal period in Dublin²⁹. Despite the high need in this area, there is minimal provision for perinatal psychiatry with only three 0.2WTE psychiatrists in the three Dublin maternity hospitals and no specific perinatal services for the remainder of the country.

²⁵ Coptly, M. (2004) *Mental Health in Primary Care*. South West Area Health Board and Irish College of General Practitioners.

²⁶ ERHA & RCSI. (2000) *The Health of Hostel-Dwelling Men in Dublin: perceived health status, lifestyle and health care utilisation of homeless men in south inner city Dublin hostels*.

²⁷ Ayuso-Mateos, J.L., Vazquez-Barquero, J.L., Dowrick, C., Lehtinen, V., Dalgard, O.S., Casey, P., Wilkinson, C., Lasa, L., Page, H., Dunn, G., Wilkinson, G.; ODIN Group (2001). *Depressive disorders in Europe: prevalence figures from the ODIN study*. *Br J Psychiatry* 179: 308-316.

²⁸ Department of Health and Children. (2006) *Vision for Change: Report of the Expert Group on Mental Health Policy*. The Stationery Office, Dublin.

²⁹ Crotty, F., Sheehan, J.D. (2004) *Prevalence and detection of postnatal depression in an Irish community sample*. *Ir J Psych Med.* 21: 117 – 121.

Eleven years on, VfC has proven largely aspirational, as the proportion of the health budget dedicated to mental health services has fallen from 13.5% in 1984 to 5% in 2012³⁰. However, the proportion of funding has risen to 6.1% in 2016³¹, and this small upswing in funding in the past 4 years gives hope that there will further prioritisation of mental health problems, including depression, in the future.

³⁰ Faedo, G., Normand, C. (2013) *Implementation of 'A Vision for Change' for Mental Health Services. Report to Amnesty International Ireland*. Trinity College Dublin

³¹ Health Service Executive. (2016) *2017 National Service Plan*. <https://www.hse.ie/eng/services/news/media/pressrel/hse-publishes-service-plan-for-2017.html>

Depression in Japan



by Dr Kanna Sugiura, MScPH, Department of Mental Health, Graduate School of Medicine, University of Tokyo, kannasugiura@googlemail.com

The national health service in Japan covers everyone and also provides mental health services. I started to practice medicine and psychiatry in Japan in 2004. It has been 13 years and I can see how the way we talk about depression determines what it means to us and I see a positive shift in the general awareness and perception of depression.

Historically, it had been difficult for individuals to identify themselves as suffering from mental disorders when they were experiencing low moods or loss of interests. They would often consider themselves lazy and try to cover it from their families, friends, or workplace. Images around psychiatry clinics or hospitals were too negative for them to seek immediate help. Some people would come to clinics by themselves and others would come due to pressure from others. It was difficult to communicate a diagnosis to patients as a doctor, as it had instant adverse reactions from patients. They were reluctant to start treatments, particularly pharmacological. Doctors working in psychiatry were also treated with negative stigma and fear. I often came across comments such as “Are you reading my mind now?” and “Are you becoming a psychiatrist? I thought you were becoming a doctor.”

Today, mental health services are seeing people self-diagnosing and seeking support at the early stages of depression. The number of people who use psychiatric services grew from 2.04 million in 2000 to 3.92 million in 2016. Out of those people with depression were 0.42 million in 2000 and 1.1 million in 2016. People are more comfortable seeking support at psychiatric clinics when they have trouble sleeping, eating, or carrying out everyday tasks. It is easier to communicate a diagnosis such as depression to patients and their families and they are open to exploring treatment options and more likely to complete treatment. Taking time out of school or work is much more acceptable. The image of psychiatrists among the public and other doctors has changed drastically. People I meet tell me that they have experienced mental health conditions once, or want to know how to offer effective support to friends and families who have mental health conditions. Doctors and nurses from other disciplines are now more willing to consult psychiatrists and accept their recommendations.

The last 13 years have seen many positive changes at different levels of society regarding depression. For example, depression is now one of the five priority health

conditions when local governments develop health plans. CBT and other forms of talk therapy are now provided under the national health services apart from pharmacotherapy. Annual health check-ups at work places now cover mental health. Sick leaves due to mental health conditions are more common and understood. Media coverage of depression is more positive and accurate. Ultimately, people feel more comfortable to talk about depression. This is helping people with depression to seek help more quickly and access necessary treatments to manage their lives. I really hope that Japan continues this trend and the theme of World Health Day this year 'Depression: Let's talk' will help other countries and people further.

Depression in Kashmir

In the Heart



by Dr Mudasir Firdosi MBBS, MD, MRCPsych, Consultant Psychiatrist, South West London and St George's Mental Health NHS Trust London,
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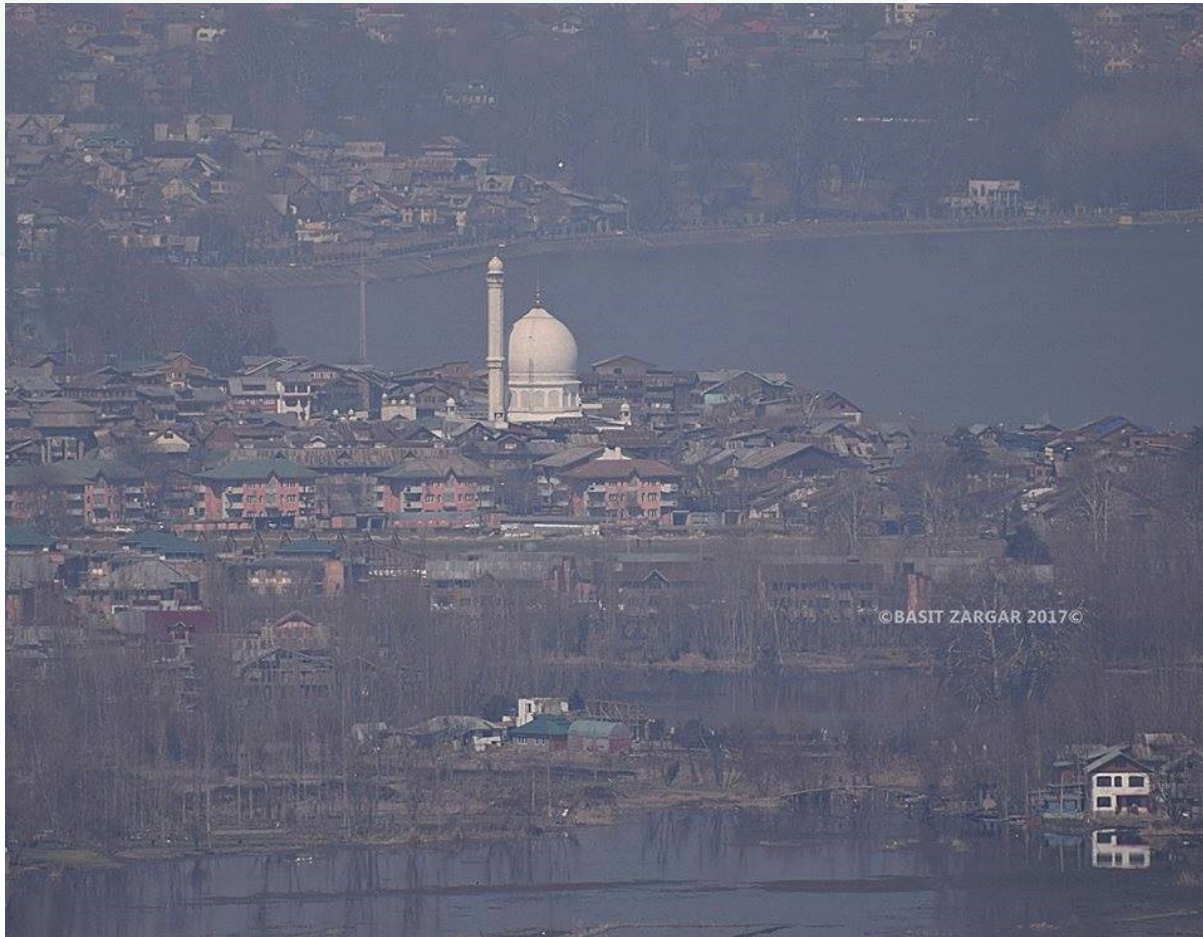


Photo by Basit Zargar

Kashmir is a picturesque valley wedged between India, Pakistan and China. I trained and later worked as a psychiatrist at the only psychiatric diseases hospital of the valley which is based in the capital city of Srinagar. I remember the walk-in clinics, where at times we had up to 300 patients waiting eagerly to have few minutes with a psychiatrist despite the huge stigma associated with mental illness. The number of people seeking help for emotional problems grew exponentially after the armed conflict started in 1989. One of our studies reported the lifetime prevalence of exposure to the trauma of about 59%³². A recent survey by Medicines Sans Frontiers (MSF) reported that about half of the population is suffering from some kind of mental illness, with 50% women and 37% men suffering from a depressive illness³³. During my research on PTSD patients, depression was again the most common

³² Margoob, M. A., Firdosi, MM, Banal, R., et al. (2006). Community prevalence of trauma in south Asia: Experience from Kashmir. JK-Practitioner, 13(Supplement 1), S14-S17.

³³ Medicine Sans Frontiers (Doctors without Borders) "Kashmir Mental Health Survey 2015" https://www.msfindia.in/sites/india/files/research_summary.pdf

comorbidity in more than 80% of the study sample³⁴.

One can argue that the diagnostic criteria as suggested in the ICD and DSM may not fully hold true in the local cultural context for the diagnosis of depression or even other disorders. Asking the golden question, “How is your mood?” usually gets a blank response. People often talk in the context of ‘heart’ when talking about their emotions and feelings, rather than the mind. Typically, someone with depression would come saying, “My heart is not good”, usually pointing to their chest. I remember asking, “How is your heart?” more often than “How is your mood?” Even the people from middle class and educated backgrounds would find it hard to discuss mood. The same is true about anxiety disorders with palpitations and other somatic symptoms often being taken as a symptom of physical illness.

People usually do not come to the doctor with an idea that they will get treatment for depression or even that they may be depressed. It is usually the physical symptoms like tiredness, pain, palpitations, memory difficulties, medically unexplained symptoms, and weakness in limbs and headaches that bring them to the doctor. Conversion symptoms are the most common presentations to the A&E department, typically a teenage girl not able to talk, move a limb or being unresponsive. This has a great cultural significance and is protective. If a woman reports feeling low to her husband, she would hardly be taken seriously and probably get told off for being lazy. However, when someone reports pain or physical symptoms, it is often taken seriously and considered a valid reason to seek help from a doctor.

Depression and other mental health problems form the biggest group of illnesses and burden of disease in the local population. With such a variable presentation of symptoms, patients often go to all kinds of specialists, quacks and faith healers. This results in unnecessary costs, inadequate or wrong treatment and, at times, iatrogenic harm. There is a need for training doctors and other health professionals in better identification and treatment of depression and other mental health disorders. There has been some awareness both among the doctors and the general public in seeking right help for mental health problems. Finally, medication still remains the sole therapeutic modality, keeping in view the lack of allied professionals like psychiatric nurses, psychologists and therapists.

³⁴ Firdosi, M.M., Margoob, M.A. (2016) *Socio-demographic profile and psychiatric comorbidity in patients with a diagnosis of Post Traumatic Stress Disorder—A study from Kashmir Valley*. Acta Medica International.3(2):97-100

Depression in Kenya



by Moses K. Nyongesa, MSc Global Mental Health candidate

Globally, depression is one of the leading cause of disability and is also a major contributor to the global burden of disease. Recent estimates from the WHO show that over 300 million people around the world are depressed³⁵. Kenya, not an exception of this global picture, has about 1.9 million depression cases. It has been ranked fifth among African countries with the highest number of depression cases after South Africa (2.4 million cases), Democratic Republic of Congo (2.9 million cases), Ethiopia (4.5 million cases) and Nigeria (7.1 million cases)³⁵.

A large proportion of depression cases in Kenya may still be under-detected and therefore undertreated. The 1.9 million figure above may only be reflective of the diagnosed hospital cases. On the other hand, what might be missing and therefore underreported is the proportion of individuals in the community who are depressed but not seeking any form of help because of various reasons. On top of the list is stigma. Stigmatization of mental illness in Kenya is a common problem, so much that the original name of a tertiary mental health hospital in the country – Mathari Mental Hospital – had to be changed to drop the word ‘mental’ because many people were shunning it³⁶. The move has not greatly changed the attitude of Kenyans against mental illness nevertheless. Many still shy off from seeking help because of the fear of being branded ‘mentally ill’ by the community. On the other hand, it is also true that majority of Kenyans may not be aware that they are depressed. It is quite common to hear people talk of being ‘stressed’ or ‘thinking too much’ but since this is regarded as normal day-to-day experiences, rather than a mental health concern warranting attention like, say, malaria or any other form of physical illness would, help seeking behaviour is generally poor. The shortage of mental health experts to effectively diagnose and treat depression in Kenya may also be another reason. It was estimated that about 30% of people seeking outpatient services in local health facilities had a treatable mental illness but most end up being misdiagnosed³⁷. As of 2010, Kenya had only 70 psychiatrists (24 in private practice) and 250 practicing psychiatric nurses for a population well above 38 million people³⁸.

³⁵ WHO. (2017). Depression and other common mental disorders: global health estimates. Retrieved from <http://apps.who.int/iris/bitstream/10665/254610/1/WHO-MSD-MER-2017.2-eng.pdf?ua=1&ua=1>

³⁶ Karanja J. (2011). Why Kenyans would rather take the mentally ill to a faith healer. Daily Nation. Retrieved from <http://www.nation.co.ke/news/Kenyans-would-rather-take-the-mentally-ill-to-a-faith-healer-/1056-1122722-om6yin/index.html>

³⁷ Siringi, S. (2001). Doctors in Kenya call for fair mental health policy. *The Lancet*, 357(9264), 1273.

³⁸ Kiima, D., & Jenkins, R. (2010). Mental health policy in Kenya-an integrated approach to scaling up equitable care for poor populations. *International Journal of Mental Health Systems*, 4(1), 19.

In Kenya, just like most resource-poor settings, poverty and unemployment are among the leading causes of depression for the population. A diagnosis of HIV is also an added stressor. A recent study has estimated a prevalence of 28% for comorbid HIV infection and depression³⁹. There is also an emerging trend of depression among the youth, especially those within the education system. A study looking at depression among university students in Kenya reported that out of the 923-student sample, 35.7% and 5.6% had moderate depressive symptoms and severe depression respectively and this was significantly associated with year of study, economic deprivation, and academic performance among others⁴⁰. In terms of coping strategies to persistent depression, drug or substance abuse, especially alcohol (more so among men) is common in the Kenyan context. There are also suicide cases due to depression, but since suicide is a crime in the country, it is often concealed⁴¹, another reason why we might be getting the statistics wrong.

³⁹ Seth, P., Kidder, D., Pals, S., Parent, J., Mbatia, R., Chesang, K., . . . Katuta, F. (2014). Psychosocial functioning and depressive symptoms among HIV-positive persons receiving care and treatment in Kenya, Namibia, and Tanzania. *Prevention Science*, 15(3), 318-328.

⁴⁰ Othieno, C. J., Okoth, R. O., Peltzer, K., Pengpid, S., & Malla, L. O. (2014). Depression among university students in Kenya: prevalence and sociodemographic correlates. *Journal of affective disorders*, 165, 120-125.

⁴¹ Nyaboga Kiage, & Angela Oketch. (2017). WHO report reveals 2m Kenyans are depressed. *Daily Nation*. Retrieved from <http://www.nation.co.ke/news/report-reveals-2m-Kenyans-depressed/1056-3828982-134wls7/>

Depression in Lebanon

Jumping out of the frying pan and into the fire



by Dr Ahmed Hankir, Associate Professor of Psychiatry, Carrick Institute for Graduate Studies (USA), Core Trainee in Psychiatry, Leeds and York Partnership Trust (UK)

“It was like jumping out of the frying pan and into the fire,” my mother would often say to those who would ask her what it was like for her when she migrated from Beirut to Belfast in the early 1980s. This was during The Troubles in Northern Ireland and the brutal and bloody civil war in Lebanon, which is when the massacres of Palestinians in the refugee camps Sabra and Shatila in Beirut took place.

There is something singular about living in a war zone and experiencing conflict at such a large scale that has a profound effect on a person’s psyche and renders an indelible mark (often scar) on your consciousness. You can’t really explain it with words, you must experience it. For me, I will never forget 18th April 1996, which was during Operation Grapes of Wrath, the name of that instalment of war between Israel and Lebanon. I was living in Lebanon at the time and remember a father who had returned to his home in Qana, a provincial village in the South which had been reduced to rubble due to air raids. Among the debris, he discovered the dismembered limbs and corpses of his children and wife. His wailing still pierces my soul even today. 800 Lebanese civilians who had taken refuge in a United Nations compound were also killed and four Fijian United Nations Interim Force in Lebanon soldiers were seriously injured.

“Everyone has a breaking point, weak or strong, cowardly or courageous, war frightened everyone witless,” said C.S Myers in *The Lancet*⁴². Karam et al published a paper titled ‘Major depression and external stressors: the Lebanon Wars’ in the *European Archives of Psychiatry and Clinical Neuroscience*⁴³. They examined the effect of war events and pre-war depression on the prevalence of major depression during war in Lebanon and revealed that individual levels of exposure to this type of conflict and a history of pre-war depression predict the development of depression during war. This fact has far-reaching consequence. For example, many of the new generation in Lebanon were raised by parents who endured the Lebanon Wars and thus their upbringing may have been influenced by psychopathology, indirectly if not directly. My family was no exception and this was certainly a contributing factor

⁴² C.S. Myers, (1915) *A Contribution to the Study of Shell Shock*. *The Lancet*, 316-320.

⁴³ Karam, E.G., Howard, D.B., Karam, N. (1998) *Major depression and external stressors: the Lebanon Wars*. *Eur Arch Psychiatry Clin Neurosci*.248(5):225-30.

towards my decision to enter the Royal College of Psychiatrists training scheme in England. I saw first-hand how distressing mental illness can be for sufferers and their loved ones and I wanted to do something about it.

Today, 1 in 4 people in Lebanon are Syrian and whenever I travel to Beirut I witness the cruel effects of trauma on the psychological well-being of these people. I'm hoping that my personal experiences will enable me to identify with Syrians and other people from vulnerable groups who are under mental distress and empower me to heal their psychological wounds in some way or another.

Depression in Lesotho



by Kopo Manamolela, Psychiatric Nurse, Berea Hospital

Depression is one of the challenging mental health conditions in Lesotho. In most cases it goes unreported until the late stages whereby measures to manage the condition are compromised and result in admission to hospital.

Contributing factors to depression, particularly in Lesotho include poor socioeconomic issues: such as high unemployment rate among young people, either academics or non-academics; poverty as some people find themselves trapped in a vicious circle of poverty despite measures they take to get out of it. This is due to traditional family structure of the Basotho, where one member of the family may be a breadwinner for the whole extended family and the effects of unpredictable climate changes which have made it almost impossible for farming. Most people are factory workers and domestic workers with minimum income either in the country or in neighbouring South Africa, thereby having to leave their families, resulting in a stressful situation.

Psychosocial issues also play a major role in depression. Divorce, loss of job, the current unstable political situation, chronic illnesses such as HIV/AIDS and bereavement are other contributing factors to individuals and their families.

Adolescent depression and childhood depression are also being diagnosed in health settings. Health care workers are also high-risk groups because of having to work under stressful conditions with lack of staff and facilities and approaching retirement. Measures to diagnose and manage depression early remain a challenge due to fear of stigma, understaffed hospitals, lack of mental health specialised workers and negative attitude of health workers towards mental health.

Mental health personnel are trying to integrate mental health into other health services but this is a slow process due to resistance and fear from other disciplines. Lack of resources such as transport, fuel, audio-visual materials etc. hinders awareness and training campaigns.

Depression in Liberia



by Kolee Gboyo, Mental Health Clinician, Maryland County, gboyokolee@gmail.com

Depression, which can be defined as sadness or low mood characterized by poor sleep, poor appetite, headache, social isolation and sometimes suicidal thoughts or ideation, is considered a serious disabling condition seen among rural community dwellers in south-eastern Liberia (Maryland County). It can be graded from mild to moderate and severe. However, in my experience as a mental health clinician working with rural community dwellers in both facility and community mental health programs, I have noticed that most community dwellers with depression do not even know that they are mentally ill. They seek treatment in prayer yards with the presumption that their conditions are the result of witchcraft. Many prayer yard managers express disappointment especially when the person with depression does not adhere to prayers management. Sometimes, prayers yards are also successful in managing depression cases, owing to the fact that drugs are the last option, but talk therapy works well both at facility and community levels, depending on the severity.

It has also been discovered that more women come down with depression than men. This is attributed to the role of women for the upkeep of their homes in terms of provision of food, care for their children and their husbands as well. Polygamy is also highly practiced in this part of Liberia, where a man gets to marry two or more wives without treating all equally.

This year Liberia will mark World Health Day with a solid programme which includes service messages, SMS, training of religious and traditional healers and many other activities. Although several mental health community support group activities have been carried out by health partners in several communities to create awareness and improve the knowledge of community dwellers about depression as an illness, monthly mental health data collection from health facilities across the county (Maryland) still constitute of up to 15% depression cases. Over five cases of suicide deaths have been reported during the period under review (March 2016 – March 2017). Depression is one of the silent killers, yet it is seemingly unnoticed by community dwellers and some health authorities.

Depression in Malaysia

Small Talk over an Old Block



by Dr Ravivarma Rao Panirselvam, Department of Psychiatry and Mental Health, Hospital Bintulu, Sarawak and #LamanMinda Group, ravivarmarao@gmail.com



Our ride took a break in this valley for a moment of quiet before the task ahead. My name is Ravi and I work in Bintulu, Sarawak. This trip is part of our regular community mental health visit to a town by a tributary to the mighty Rajang River. Our mental health team cares for a region of approximately 30 000 km² which is largely rural, loosely populated and under-accessed.

The picture above is a conjecture to mental health morbidity in rural areas which is less spoken and recognised, especially depression. Depression has often been painted as urbanite illness. While urban lifestyle and financial crunches are real, rural living has its own set of stressors. This is profound, especially on the elderly who are caught in a tide of a world once known.

Rural Sarawak is rich in tradition and community living. Communities live in a single extended unit known as the longhouse where multiple families coexist as neighbours and functional economic units. The concept of retirement in rural communities is abstract. People tend to engage in economic activities like small scale farming and craftsmanship till their health would not permit it anymore.

Furthermore, Sarawakians have enjoyed a higher life expectancy than the national average.

Alas, development and progress has washed on the banks of the heartlands which has led to migration and movement. Traditional economies have hybridised into societies which bear some semblance of the past with alien features of the future. In context of geriatric depression, subtle changes go unnoticed. Modernity brings a disease burden of its own and as physical health fails, seclusion increases. The changing fabric of society sustains the illness. The elderly who became depressed are either normalised for aging or mistaken for dementia (further mistakenly normalised). Only at times when a profound lack of self-care sets in, is when healthcare services are sought.

Upon crossing the diagnosis hurdle, our mental health team starts the real work with psychoeducation i.e. talking to the service user, the family and at times longhouse members. The discussion would stem on the nature of illness and branch into management options i.e. lifestyle changes or medications. It is crucial that we involve primary care services to follow-up on the progress of the service user as distance and lack of phone reception is a commonality rather than an exception. Psychological services are scarce but adaptations are ingenious. A noteworthy example would be a form of behavioural activation using day-to-day activities around the longhouse. Increased engagement was able to reintroduce activities, including farming, to the service user, aiding recovery and return of quality of life.

It again underpins the importance of the biopsychosocial model of management and engagement of the local community. By turning difficulties into possibilities, improvisation has enabled quality care in a place that is four hours away from the nearest hospital. It also speaks volumes on the need to have the conversation on geriatric depression, not only among service users, but society at large as it is not only treatable but curable. The elderly are our repository of wisdom and their improved quality of living will enrich all our lives. Awareness leads to empowerment, so let's talk!

Depression in the Maldives



by Dr Shaazneen Ali, Specialist Registrar in Central and North West London NHS Foundation Trust, London and Co-founder of Mental Health Awareness Foundation, the Maldives, admin@mhafmaldives.org

The tiny island nation of the Maldives is described as a paradise on earth by many, and one may think that living in this Eden would provide immunity from depression. However, just as depression sees no socio-economic boundaries, it sees no geographical boundaries world-wide either. There is very limited research in the Maldives in the field of mental health but there appears a stark discrepancy in these figures when just conversing about it with small groups of professionals. The various professionals we have come across in the Mental Health Awareness Foundation's (MHAF) training programmes speak about depression being a common illness in their local communities amongst various population groups and also about the immense stigma associated with mental disorders.

In 2003, Ministry of Health conducted a nation-wide survey to assess the magnitude of mental and neurological disorders^{56,57}. This survey found that more than 29.1% of the respondents reported that they had a mental health condition, with nearly 5% suffering from anxiety and depression and nearly 4% reporting somatic symptoms. Another finding of note was the increasing rate of suicide, particularly in the youth⁵⁷. However, no formal research figures are available about this hugely ostracised act in the Maldives. Though not all suicides are due to depression, the link between suicide and mental disorders such as depression is well established⁵⁸.

The National Drug Use Survey 2011/2012 revealed that an estimated prevalence for the capital island of Malé and the atolls were 6.64% and 2.02% respectively⁵⁹. However, it may be that the actual prevalence rates are higher⁵⁷. The survey also showed that mental health problems were common in this population⁵⁷. Data on mental health problems among the drug users implied that about 15% in Malé and 9% in the atolls had been diagnosed with a psychological disorder⁵⁹. More than a third of current drug users in Malé stated that they were affected by a 'mental problem'⁵⁷. In another study, Global School Based Student Health Survey 2009, in the Maldives 35.5% of students felt 'so sad or hopeless almost every day for two weeks or more in a

⁵⁶ Niyaz, H., Naz, A. (2003) Mental health situation in the Maldives. Male': Ministry of Health.

⁵⁷ National Mental Health Policy 2015-2025, Draft 2014- Version 3; Available from: <http://www.searo.who.int/maldives/mediacentre/ental-health-policy-2015-2025.pdf?ua=1>

⁵⁸ Suicide fact sheet [Internet]. World Health Organization. World Health Organization. Available from: <http://www.who.int/mediacentre/factsheets/fs398/en/>

⁵⁹ United Nations Office for Drugs and Crime. (2012) National Drug Use Survey Maldives 2011/2012. Male': United Nations Office for Drugs and Crime.

row that they stopped doing their usual activities during the past 12 months'⁶⁰. Further research is required in establishing the prevalence of depression and other mental disorders in the country.

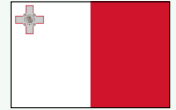
In the Maldives, stigma appears to be the biggest barrier to addressing this leading cause of global burden of disease⁶¹. MHAF has been able to work on its goals, with some very generous donors, volunteers and collaborators such as the Ministry of Health, Maldives. However, at the same time, our goals receive stigma from some sources. Until we address the stigma within our society, this will remain the biggest hurdle to climb in order to tackle this crippling illness. Stigma and discrimination against patients and families prevent people from seeking mental health care⁶². We hope that on this World Health Day, 7th of April 2017, the message of the World Health Organisation's 'Depression: Let's talk' campaign will help address this silent killer. MHAF in collaboration with the Health Protection Agency, Ministry of Health, Maldives, is working on a number of campaign projects for World Health Day to highlight this debilitating, but treatable global health issue and to help fight the stigma associated with this condition.

⁶⁰ World Health Organization and Centre for Disease Control and Prevention. (2009) Global School Based Student Survey, Country Report, Maldives, Ministry of Education in collaboration with Ministry of Health and Family

⁶¹ Ferrari, A.J., Charlson, F.J., Norman, R.E., Patten, S.B., Freedman, G., Murray, C.J.L., et al. (2013) *Burden of Depressive Disorders by Country, Sex, Age, and Year: Findings from the Global Burden of Disease Study 2010*. PLOS Medicine. Public Library of Science

⁶² 10 facts on mental health [Internet]. WHO | 10 facts on mental health. Available from: http://www.who.int/features/factfiles/mental_health/mental_health_facts/en/index5.html

Depression in Malta



by Siobhan Page, Medical Student, siobhan@siobhan.co.uk

Depression paints a dark, painful, gloomy cloud over how individuals see the world, themselves and their future. Not only does depression affect an individual's mind, but it also affects their body, their spirit, and every aspect of their life. Worldwide, depression is thought to affect almost 10% each year. However, it is estimated that between 14-17% of the Maltese population have suffered from depression throughout their lives⁴⁴. Despite this figure being above the EU average, the suicide rate in Malta is amongst the lowest in the EU.

Results show that 51% of first-year students at the University of Malta felt that they were experiencing a problematic level of depression⁴⁵. Thankfully, the University of Malta offers a fantastic counselling service, available to any student that is struggling. Additionally, many departments at the University of Malta include compulsory study units that emphasize personal development and the importance of self-reflection. For example, medical students are required to meet with psychologists in pre-clinical years and throughout their transition into clinical years, in order to discuss any problems that they may be facing with their course, as an attempt to minimize stresses.

Not only are young people in Malta supported at higher levels of education, but mental health promotion and education is a key component of the national curriculum for children aged 11-15 years⁴⁵, and psychological services are available to all. Children are invited to visit the psychiatric hospitals, where knowledge is provided on common psychiatric problems, including depression, and the treatments available. Recent years have seen educational authorities working alongside non-governmental bodies such as The Mental Health Association to promote mental health awareness through lectures and education, both at school and at the University of Malta.

Despite huge efforts to increase mental health awareness, there is still quite a journey ahead to achieve de-stigmatization of mental health in Malta. Preliminary results from an ongoing study that I am conducting with Dr Ruairi Page (Birmingham and Solihull Mental Health Foundation Trust, UK), indicate that there are more negative attitudes towards mental health in Malta than in other countries.

⁴⁴ Mental Health Briefing Sheets: Facts and Activities in Member States. Available online: https://ec.europa.eu/health/archive/ph_determinants/life_style/mental/docs/malta.pdf

⁴⁵ Times of Malta, 2011. *Anxiety, depression affects half of first-year university students*. [ONLINE] Available at: <http://www.timesofmalta.com/articles/view/20111011/local/Anxiety-depression-affect-half-of-first-year-university-students.388607> [Accessed 9 March 2017]

It is widely believed that a large factor for this is the small size of Malta: with a population of just 425,000, and with communities being so close-knit, many fear that they cannot deal with their personal problems anonymously. Additionally, the Victorian surroundings of Mount Carmel Hospital, Malta's current psychiatric hospital, appear to contribute to the stigma surrounding mental health.

Mount Carmel Hospital was built between 1953-1961 as a replica of the Wakefield Asylum in England. Whilst it maintains its original Victorian structure, which many find unappealing and in need of modernization, psychiatric treatment services and provisions have remained dynamic; similarly to other countries, Malta has seen a shift from hospital-based psychiatric treatment to community-based systems⁴⁶, and this is expected to strengthen further in years to come, with the introduction of more community outreach teams.

It is exciting to see Malta flourish in developing its mental health care services, with major progress being seen in enhanced training amongst psychiatrists, psychiatric nurses and social workers. Numerous nationwide non-profit organisations have gained a lot of support over the last few years, including The Richmond Foundation Malta, Families for Depression Awareness, The Depression Centre and Caritas Malta Services. Despite Malta being such a small country, it is refreshing to see so many charities reaching out to help individuals suffering with depression, by providing a huge amount of support (via support groups and online forums) and through close work with the Health Ministry and media to promote mental-wellbeing and awareness.

⁴⁶ Grech, A. (2016) *Epidemiology of serious mental illness in Malta - Consequences for developing a new psychiatric hospital and community psychiatry*. *Psychiatria Danubina*, [Online]. Vol 28, Suppl 1, 108-11-. Available at: http://www.hdbp.org/psychiatria_danubina/pdf/dnb_vol28_sup1/dnb_vol28_sup1_108.pdf

Depression in Myanmar



by Dr Nwe Thein, Consultant Old Age Psychiatrist, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Founder/Trustee, Mind to Mind Myanmar (UK charity registration number 1165005)

When I was a medical student in the mid-1990s in Myanmar, depression was merely a topic studied for the exams. Patients with depression were not so visible in the institution where we went for the placement in psychiatry. Students were more fascinated by the strange psychotic symptoms in schizophrenia than the sad and gloomy symptoms of depression.

In any case, psychiatry was not a subject that attracted serious attention from the medical students or doctors and specialists. The undergraduate medical curriculum paid very little attention to the mental health aspect of a person's health. Mental health services also suffered a similar lack of interest from the policy makers.


According to the WHO AIMS report in 2006, only 0.3% of the total health budget was invested in mental health.

Recent figures from the charity mental health clinics that are funded by our charity showed depression as one of the top morbidities among clinic attendees. It is nowhere near being representative of the whole population in the country, but it has certainly highlighted that depression is a common mental health problem in Myanmar like anywhere else in the world.

In Myanmar, depression is not much known or accepted as an illness. People tend to take it as a predictable part of life and try to get over it by getting on with their routines. Those with mild symptoms recover while those with more severe symptoms worsen over time. By the time they are brought to the hospital, sometimes in restraints, by their families, patients are very ill and lacking an insight into their illness and its associated risks. Specialist mental hospitals in Myanmar, until recently, could offer only unmodified ECT. Understandably, patients and clinicians dreaded this option, although it could be the only life-saving treatment of severe depression.

There is also a belief that the religion (Buddhism) protects people in Myanmar from depression. It is true for mild symptoms related to stress; people take refuge in the religious faith, practise mindfulness and insight meditation, or perform the rituals which are in fact more traditional and cultural than religious. However, not everyone in Myanmar is Buddhist or particularly religious. More crucially, people who suffer moderate to severe depression need specialist medical attention and treatment.

In recent years, the suicide rate in Myanmar has gone up a few positions in the list of



25 top causes for YLL (years of life lost) quantifying the premature mortality.

According to the WHO report (2012), Myanmar's suicide mortality rate was 12.4 per 100,000 population, higher than the global average of 11.4. With the known link between suicide and depression, this places emphasis on the need to diagnose and treat depression early and properly.

There is hope and optimism. In a country where social cohesion is still strong, Myanmar may not require all the formalities of the Western way of managing Depression, but rather a pragmatic combination of strands drawn from the evidence-based Western model and the inexpensive psychosocial approach based in its social structure, community spirit and existing helpful practices. In order to achieve creative and innovative ways of managing depression, people need to talk more and talk openly about depression first.

Depression in Nepal

An experience with depression in the remote far-west region of Nepal:
salient features



by Dr Suraj Tiwari, Consultant Psychiatrist (under Ministry of Health, Nepal)
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As a part of my regular postings under the Ministry of Health, I recently worked as a consultant psychiatrist in the Seti Zonal Hospital, located in the Kailali district. This hospital is the major tertiary referral centre for around eight other districts located around the Seti Zone. Here I got an opportunity to have an experience with depressive illness in the population, which may have some characteristics of their own.

The general population consists of people from wide variety of caste and culture. Most people live in the hills and have low socioeconomic status, the major source of earning being agriculture and migrant jobs. Their level of literacy level and awareness is also low. They have also seen and suffered the conflict during the Maoist revolution. People in general have plenty of myths and misconception about health and illness, and mental health and mental illness is no exception.

During my stay in this region, I observed that mental illness is quite common, of which neuroses are the major chunk. After anxiety disorder, depression is the next most common mental illness, but often gets missed due to various reasons.

Depression is seen in all grades – mild, moderate, severe; all ages – children, adults, elderly; all genders; all strata of society, and concurrent with or without medical condition. Most cases of depression are reactive to external events or secondary to other chronic medical condition like HIV, TB, DM, etc. Some are familial. Only few are endogenous.

These are the typical scenarios in people with depression:

In the first one, depression is not considered illness at all. In this region, the mental illnesses, except the dramatic ones like psychoses, conversions, panic attacks etc. are usually not considered illness at all by the lay people. Therefore, depression may be wrongly judged as faking, fatigue, or punishment by spirits or gods/goddesses. This is mainly due to the deficits in education and awareness of the people.

In the second scenario, depression is considered a form of medical or physical condition. If depression is at all considered a form of illness, it may be misinterpreted as a form of physical or medical condition like general weakness, soft tissue injury, gastritis, and may be treated by vitamins, analgesics, antacids, etc. This is because

depression often presents with somatic complaints like multiple aches, tingling sensation, burning sensation, heaviness, especially in people who come from the hills. Unavailability of health professionals trained in mental health is the main reason for inappropriate treatment in these cases.

In the third scenario, depression is rightly recognized as depression, and in a few fortunate ones, timely. These are treated appropriately by health professionals trained in mental health – paramedics, doctors and psychologists through the health posts, primary health centres, district hospitals, the zonal hospital and the regional hospital in the government system, as well as through the private hospitals and the NGOs. Most psychotropic drugs are available in the private sector. However, in the government institutions only a few items are available as free supply.

Surprisingly, psychotropic drugs are not the most preferred mode of treatment in this region for the mentally ill. Faith healing in the form of pujas by pundits, rituals by jhakris, remedies by astrologers is the most preferred mode of treatment, the practice and belief depending upon the caste and the culture. Often these are performed as the sole treatment, and many a times these are performed supplementary to the psychotropic treatment. Some people use the help of Ayurvedic medicine, homeopathic medicine, energy healing, etc based on their beliefs. These alternative therapies seldom prove to be sufficient to deal with depression as a sole treatment.

The very few health personnel trained in or knowledgeable about mental health and treatment are scattered in the primary health centres, district hospital, regional hospital and the zonal hospital, where most patients fail to reach due to geographical and financial barriers. However, a few from well-off families may travel to other cities in Nepal (Kohalpur, Nepalgunj, Kathmandu) and in India (Lucknow, Bareilly, Delhi), which may take a day or two. Those who travel to these cities do so not only for better and advanced treatment facilities, including inpatient facilities, but also to avoid stigma and discrimination faced in the local region.

There are some characteristic features about depression seen in this region.

A lot of patients are from hilly region and most are uneducated. Somatic complaints, which include multiple aches, tingling sensation, crawling sensation, burning sensation, headache, are a common category of symptoms in depression. Most people with depression do not complain of low mood and anhedonia, instead they complain of fatigue. However, most people do agree on those symptoms during the interview.

Most people with depression are usually not convinced that all their symptoms are due to depression. Some clients, however, would easily agree to take antidepressants, because not only they want to get better but they want to get back to work quickly. One problem during treatment is compliance. Most would reach remission in around 2 months, and would want to stop medications and keep insisting if they could

shorten the course of treatment. Some cases are lost to follow-up, and most turn up after relapse. Not only non-compliance but also inadequate family support and overburdening work stress are factors for relapse.

Family support is inadequate in most cases because family members are away from home working in other district or abroad. Females are especially overburdened with work because they have to look after their husbands, children, other family members, house, cattle and farm.

Another factor for the relapse as well as non-remission is alcohol abuse, especially in the males. Cannabis abuse also contributes for relapse which is usually done for recreational purpose.

By far poisoning is the most common mode of suicide, using organophosphorus which is readily available as a pesticide at home for their farm. The next most common mode is hanging.

The burden of depression is substantial.

The term depression is also used to mean any neurotic illness, i.e. mental illness except for the psychoses. However, depression is the most common illness after the anxiety disorders. Stigma is high for depression because it is misunderstood as a form of weakness of body or nerves or mind, punishment given by God for their sins committed in this or past life, transmissible to the next generation in families. That is why most people with depression do not come for treatment. Some seek treatment with physician or other health professionals. Some go to treatment in far off places. Not all cases of depression may be difficult to treat, but most cases do not get identified due to various reasons, the major ones being inadequacy of education and awareness in the general population, and inadequacy of knowledge and training in the health professionals regarding mental health and illness. Thus, education, awareness, and training should be the major interventions to decrease the burden of depression.

Depression in Pakistan



by *Onaiza Qureshi, MSc Global Mental Health candidate*

Pakistan – home to approximately 182 million people of diverse races and religions who operate within limited access to healthcare, political acts of violence, and high levels of financial insecurity and social injustice. This environment is a breeding ground for mental health problems. The treatment gap for mental illness is expounded by the fact that Pakistan has a ratio of 2-3 psychiatrists per 100,000 of its population. Depression is the most prevalent mental illness and is the fourth leading cause of years lost due to disability in the country^{47,48}. Epidemiological reports around the country put the prevalence rates of depressive and anxiety disorders between 22% and 60% with incidence varying widely between urban and rural settings⁴⁹.

Among the many marginalized populations, the most vulnerable to depression are the females, the elderly, those from lower socio-economic groups and uneducated individuals⁵⁰. The most dominant opinions about the causes behind depression appear to revolve around the social factors such as poverty, insecurity around terrorism and violence and population density. Moreover, factors such as marital status, interpersonal issues and financial worries were also quoted as leading to psychosocial stressors as a consequence⁵⁰. There is also a common conception that mental disorders are caused by supernatural forces and beings such as evil Jinns (evil spirits/genie created from smoke and fire), black magic, and possession or as a punishment by God for sins committed in the past⁵¹.

There is a strong culture of stigma against depressive disorders in Pakistan. A person suffering from mental illness will yield different degrees of reaction from his community depending on the severity of the depression and its symptoms. Since depression does not manifest outward in an obvious fashion or cause visible social problems, it tends to be neglected and missed in the population when compared to more visibly noticeable disorders like schizophrenia⁵¹. It may be due to this reason that many people do not seek or access help for depressive disorders in this context.

A fully functioning and up to date mental health act exists in two of the largest provinces of Pakistan; however, there is a lack of implementation for the policy to protect

⁴⁷ Taj, R. (2015). Mental health in Pakistan. Routledge Handbook of Psychiatry in Asia, 103.

⁴⁸ Institute for Health Metrics and Evaluation. Pakistan. Extracted from <http://www.healthdata.org/pakistan>

⁴⁹ Ahmed, B., Enam, S. F., Iqbal, Z., Murtaza, G., & Bashir, S. (2016). Depression and Anxiety: A Snapshot of the Situation in Pakistan. *International Journal of Neuroscience and Behavioural Science* 4(2): 32-36.

⁵⁰ Mirza, I., & Jenkins, R. (2004). Risk factors, prevalence, and treatment of anxiety and depressive disorders in Pakistan: systematic review. *Bmj*, 328(7443), 794.

⁵¹ Karim, S., Saeed, K., Rana, M. H., Mubbashar, M. H., & Jenkins, R. (2004). Pakistan mental health country profile. *International Review of Psychiatry*, 16(1-2), 83-92.

the rights of people with mental illnesses. Although small-scale non-governmental organizations have been doing their part in trying to change the state of mental health in Pakistan, the government itself needs to take responsibility for putting mental health on the agenda for policy, planning and implementation before any significant changes can be made.

Depression in Portugal



by Dr Teresa Alves dos Reis, Psychiatry resident, PhD student at NOVA Medical School, Nova University of Lisbon, alvesreisteresa@gmail.com

Portugal is a small, sunny, welcoming Southern European country. In general an increasing number of visiting tourists agree on its beauty and good quality of life, but this idyllic image is not felt or lived by a large proportion of the population, as mental health data clearly show.

The first Portuguese Mental Health epidemiologic study, published in 2013, demonstrated that Portugal had the second highest 12-month prevalence for depression in Europe. The same study showed an average waiting time to access adequate mental health care of five years. Other recent data highlight the important effect of economic crisis on the Portuguese mental state.

Despite having a comprehensive mental health plan, Portuguese mental health stakeholders agree on the extreme lack of investment and implementation of important mental health intervention measures such as focusing on early detection and treatment of depressive disorder, implementing strong therapeutic guidelines (avoiding the excessive utilisation of benzodiazepines, which is very high, actually the highest DDD utilisation comparing to other European countries), availability of psychologic treatment (Portugal has one of the smallest numbers of psychologists per capita working for the National Health Service of Portugal). At the same time there isn't any national policy for the promotion and prevention of depressive disorders. We could say that melancholy is an inherent characteristic of Portuguese people, inherited from *fado* and the feeling of *saudade*, but the reality felt by the people suffering from depression may have other more important factors to blame.

Depression in Russia



by Dr Alexandr Sapunov, Consultant Psychiatrist, Springfield Hospital, London, UK


According to the WHO about 350 million people, or 5% of the world population, suffered from depressions in 2012.

In the same year, about 6.7 million people were reported to have mental health problems including depressions and anxiety disorders in Russia, also according to the WHO. However, little is known about how many of these 6.7 million people suffered from depression since Russian official statistics (ROSSTAT) provides almost no insight.

As far as Russian mental health professionals' opinion is concerned, they largely agree that the WHO statistics is way too conservative. According to Stanislav Poltorak, who is the leading researcher at the St. Petersburg V.M Bekhterev Psychoneurological Research Institute, depressions may affect as much as 25% of Russian population, whereas the majority of practicing psychotherapists assume that 20% is more or less accurate estimation based on their clinical experience. According to Vladislav Plotnikov, the researcher at the International Centre for Economics, Management and Health Policy of the Higher School of Economics, the real percentage of the population suffering from depression and anxiety disorders varies between 10% and 20%.

The difference of opinions can be partially attributed to widespread negative attitude towards psychiatry among Russian population. People are afraid of being labelled as 'crazy' or 'mad'. For the male population seeking help for mental health issues is largely associated with being 'wimpy' and 'weak' which is not in line with the cultural perception of being male. That is why the so-called 'masked depression' and untreated depressive conditions are very common in Russia. It comes as no surprise that sales of antidepressants did not exceed \$ 0.03 billion during the first 10 months of 2016 (as per Russian Association of Pharmacy Chains) in contrast to the US where sales reached \$ 9.6 billion in 2016. On top of that it was reported that sales of antidepressants in Russia fell by 0.5% during this period, compared to a previous year. Interestingly, prices for these products were going up more slowly than for any other drugs in Russia. It is important to notice, however, that antidepressants are not included in the list of drugs covered by social funds and costs associated with the purchase of antidepressants are entirely on the patient's shoulders.

Despite limited information about the incidence and structure of depressions in Russia there are some ways to look into it. The WHO suggests that 60% of suicides



committed can be connected to depressions. In accordance with ROSSTAT data, suicides were the main cause of death due to external factors (i.e. not related to the physical health directly) in 2015 in Russia. There were overall 24982 deaths registered from suicide and this number is higher than the number of deaths due to accidents on all means of transport combined. During this year the suicide rate amounted to 17.1 per per 100,000 people in Russia which ranks the country among those with the highest rates. For comparison, the UK suicide rate was 10.9 deaths per 100,000 people in 2015 (as per the Office for National Statistics report). Comprehensive studies in this field are much needed in order to understand the structure of depressions, the risk factors unique for Russian society, as well as to offer a standard of care.

Depression in Sierra Leone



by Dr Helen Thomson, Psychiatry Specialist Trainee Doctor

‘Le wi tok’ is the Krio for ‘let’s talk’: one of the key messages being spread in Sierra Leone about depression for World Health Day 2017. However, in Sierra Leone, you are very unlikely to hear anyone talking about depression.

As part of my work as mental health coordinator for King’s Sierra Leone Partnership, I have been providing clinical supervision for the 19 trained mental health nursing staff working in each district. A large and essential part of these nurses’ work is community sensitisation, efforts to reduce stigma and mental health awareness raising. Without these efforts, they would not have any patients in their clinics. Depression in Sierra Leone is a large, but mostly completely unrecognised problem. The country has experienced a devastating civil war and more recently also the largest Ebola outbreak in history, not to mention flooding, civil unrest and widespread poverty. Rates of mental health problems in the country are high. However, mental health awareness is extremely low. The strength of the local population’s cultural beliefs varies throughout the country but even in Freetown, where the public are relatively more trusting of Western medicine, the majority of patients attending clinics have more visible disorders such as psychosis. Of the very few patients presenting with depression, most seem to have healthcare staff as relatives. Even in these cases, almost all patients have visited a traditional or religious healer before coming to the clinics. When people consider mental illness here, they only think fearfully of the ‘craze yard’. They are thinking of the Sierra Leone Psychiatric Hospital, the only inpatient facility in the country.

There is a perception here that depression is simply laziness and the vast majority of people would never consider it to be a treatable medical condition. However, I have seen cases of very severe and disabling depression treated very simply and effectively. It is not a difficult condition to treat, even with the extremely limited resources available here. Sometimes simple psycho-education is enough to make a huge difference, explaining to patients’ families that the condition is not the person’s fault. We are trying to spread the message that people should consider going to see a healthcare worker if they have symptoms of depression; but the reality is that there are very few staff with sufficient training available in the country, and these messages are complex ones to understand for people who trust traditional medicine so completely and are so unaware about mental health problems. I am cautiously optimistic about the future of mental health services in country, but the treatment gap for depression – the number of people with depression who need treatment but do not get it – will be challenging to close.

Depression in Somalia

Difficulty of getting treatment for depression patients



by Dr Mohamed Sheikh Omar, Health and Nutrition Program Manager, Action Contre La Faim, mohamedsheikh_21@hotmail.com



Somalia health infrastructure has fallen since the central government collapse. Since then humanitarian actors have given little attention to delivering mental health services when delivering care to the affected people, while neglecting those people who are in need of mental health services, as these people lost their homes and livelihood due to war. Depression was one of the major mental health problems that many Somali people faced during and after the civil war that lead to severe consequences such as broken marriage, khat chewing for relief, health and nutrition problems and eventually disability and death.

A few Somali personnel started to rebuild the mental health from the ashes to something in which they can provide assistance to their communities and to prevent the catastrophic events that depression can lead to if not treated well. On the other hand some international non-governmental organization have started to integrate the primary health care with mental health by training their staff on mhGAP.

Dr. Faduma Abdi Maow, in charge of Laasareti Mental Hospital, said, “Depression patients’ help-seeking is little at the first stages of the illness, they usually come with other complications like bipolar disorder, drug addiction and schizophrenia sometimes, but unfortunately if the patient who need inpatient service is female, we don’t have a place to admit her – due to security issues, unlike with the men.”

According to Dr. Mustaf Habeb, “lack of sufficient knowledge, stigma and discrimination that people with mental health disease get, means that people will not

come to health facilities to seek help. On the other hand people don't recognize depression as a disease, the only time they seek treatment is when it is combined with bipolar disorder.”

There is a huge gap in seeking treatment for depression; communities don't recognize it as a disease, some may say he/she is isolating him/her self from the world. There is poor diagnosis since qualified personnel are few, which increases the risk of suffering and potentially causes disability and death if help doesn't come at the right time in the right place.

Depression in Somaliland

Perceptions of depression among Somali populations in Somaliland



by Dr Djibril I.M. Handuleh, Public Health Specialist at Medecins sans Frontieres/ Doctors without Borders

Mental health is one of the most neglected specialties in Somaliland. Internally recognized as part of Somalia, it has a population that is estimated to be 3.5 million. The mental health resources are among the least developed in the world. There are two psychiatrists practicing in the country with few physicians and nurses working in both primary care and public hospitals on mental health. A significant part of mental health services is delivered through traditional healers. There are no psychologists, social workers, psychiatric nurses and other allied health workers in the country. Mental health policy is in draft stage in Somaliland.

Here, I discuss the public perception of depression among the population. This is derived from eight years of practical mental health practice as a physician working in psychiatry. Mental health debate in public arena is starting in the country. This is mainly due to the increasing burden of mental health disorders among Somalis in East Africa and in the diaspora. In my practice, depression is the most common mental health disorder presented by most of my patients.

People have different understandings of how depressive illness may present. These vary from people who deny depression as a disorder or a medical condition. They point out that anyone who gets depression is cursed. Lack of religious practice is agreed among the public as depression. The second largest group believe it is either due to failed romantic relationships or failure. They dismiss depression as either medical or psychiatric condition.

The third and least numbering group consider depression as a medical condition. This group includes most of the patients who present in both general practice and mental health settings. They present with somatoform symptoms such as headaches, generalized body aches and dizziness. This can easily confuse even physicians into not taking focused psychiatric history or mental health exam.

Somalis think they are resilient society and hard to get depression due to their nomadic and harsh life conditions. Depression is not on the agenda when Somalis discuss mental health disorders, as psychotic disorder is presumed as a mental health disorder.

Women and older people may accept a diagnosis of depression while men and other more privileged community members get nervous if they meet the criteria for depression. They call it Neerfo, meaning nerve related disorder.

Based on these facts, addressing depression in Somaliland is a heavy task at hand. There is a need to train physicians on depression and its management as patients, when they are living with depression, seek medical care from general clinicians, not from mental health specialists/practitioners.

There is also a potential to increase public awareness of depression among the community via health education initiatives at population level. A good example was in Borama, which took place at schools, prisons, community neighbours and in mosques. We also trained religious imams on depression as religious interpretations are common in Somaliland.

Depression in South Africa



by Dr Anna Walder, Psychiatry Trainee

South Africa has a 12-month prevalence of depression of 4.9%⁵². The prevalence of HIV in South Africa is 19.2%⁵³. Depression is the most common psychiatric disorder experienced by people living with HIV. Understanding the interplay between the two disorders and the challenges, when assessing and managing both the HIV and depression is vital to ensure the needs of the person are addressed.

For people living with HIV who have depression, there are many issues that arise. Depression can be misdiagnosed as HIV apathy and vice versa. Depression in a person living with HIV can present with predominantly somatic symptoms. These may be attributed to the HIV illness rather than depression, which then goes undiagnosed and untreated. Untreated depression leads to poor compliance with treatment; missed clinic and hospital appointments, isolation from family and communities, all factors that are known to lead to a poor prognosis.

Depression is one of the known risk factors for poor antiretrovirals (ARV) adherence. Studies have shown that successful treatment of depression with medication or psychological intervention improves adherence with anti-retroviral treatment⁵⁴. Appropriately managing the depression has a vital role in managing the HIV condition. However, the ARV treatment does come with its own risks. It is known that anti-retrovirals may lead to neuropsychiatric side-effects, Efavirenz being the most high-risk. This must be taken into consideration when deciding on treatment regime. The needs of people living with HIV and severe mental illnesses such as depression have been increasingly identified as requiring specialist input. In 2006 the Neuropsychiatric Division of the Department of Psychiatry and Mental Health in Groote Schuur Hospital, Cape Town, was opened. It has since grown to encompass much more with clinical, teaching and research programs.

Despite awareness campaigns addressing stigma and discrimination, people suffering from depression often are unable to access care. The fear of being stigmatised can often prevent people with HIV accessing care for their depressive illness. The South African Depression and Anxiety Group⁵⁵ is the country's largest advocacy group. They provide awareness services, advocacy, support groups and outreach work. This is a vital part of identifying people in the communities living with HIV and Depression and ensuring they get the treatment they need.

⁵² Herman, A.A., et al. (2009) *The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders*. S Afr Med J 99: 339-344.

⁵³ <http://aidsinfo.unaids.org/>

⁵⁴ Moosa et al. (2012). *Treating Depression in HIV-positive Patients Affects Adherence*. Southern African Journal of HIV Medicine. 13:3

⁵⁵ www.sadag.org.za

Depression in Sri Lanka

Moving forward by addressing the past



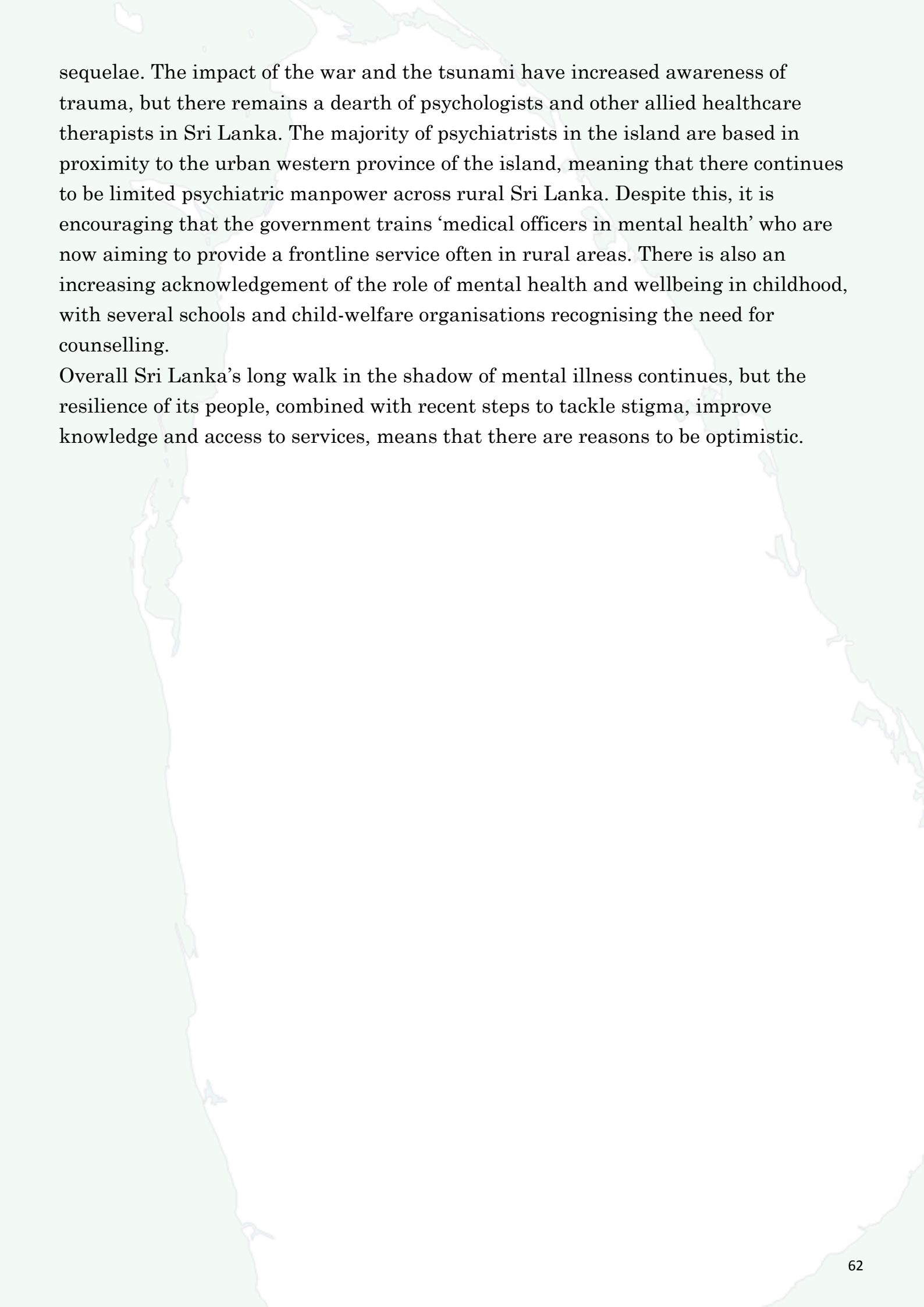
by Dr Asanga Fernando, Macmillan Consultant Liaison Psychiatrist & Co-clinical Director of Simulation, St George's University Hospitals NHS Foundation trust, London, asanga.fernando@kcl.ac.uk

Sri Lanka has faced a unique set of challenges from the mental health perspective. The end of Asia's longest running civil war in 2009 and the Boxing Day Tsunami of 2004 have contributed to an increasing awareness of mental illnesses across the island, whilst also highlighting the enormous challenges that exist in effective island-wide mental health coverage. In many ways, the major challenge in addressing mental health problems, including depression, is, as it is in many places, stigma. Regardless of ethnicity or social class, Sri Lankan society is strongly family-based, and as such, it tends to be the supportive families of those affected by mental illness that carry its burden. Families of course want their loved ones to succeed in a society where identity is dependent on having a successful job, which in turn increases the prospects of marriage, and therefore, as in many other places, professional help for mental illnesses isn't sought as early as it could be due to prevailing stigma. Despite this, there have been notable recent efforts, including use of TV, mass media and social media, which are helping to improve awareness.

Depression continues to be a major cause of morbidity in Sri Lanka. It is notable that there is no word specifically for it in the Sinhala language. The closest word to describing depression is 'dukha' which literally translates as 'sadness'. The presentation of depression across Sri Lanka manifests more commonly as somatisation and often results in extensive medical investigation prior to screening for psychiatric symptoms. Depression continues to be frequently associated with trauma, comorbid with anxiety disorders and also with alcohol misuse in men, with the wider impacts of alcohol misuse tangible in post war Sri Lanka, including increased road traffic accidents.

Although the use of faith and traditional healers to treat mental illnesses has significantly reduced over the years, Ayurvedic medicine remains a popular and often more acceptable alternative to western medicine especially in rural areas. As such, the local 'native doctor' or 'veda mahathaya' may be the first point of contact for those affected with mental illness.

As Sri Lanka has recently transitioned from a 'developing' country to a 'lower-middle income' country, the burden of disease is shifting from communicable to non-communicable. As such, people are living longer, often with more mental health



sequelae. The impact of the war and the tsunami have increased awareness of trauma, but there remains a dearth of psychologists and other allied healthcare therapists in Sri Lanka. The majority of psychiatrists in the island are based in proximity to the urban western province of the island, meaning that there continues to be limited psychiatric manpower across rural Sri Lanka. Despite this, it is encouraging that the government trains ‘medical officers in mental health’ who are now aiming to provide a frontline service often in rural areas. There is also an increasing acknowledgement of the role of mental health and wellbeing in childhood, with several schools and child-welfare organisations recognising the need for counselling.

Overall Sri Lanka’s long walk in the shadow of mental illness continues, but the resilience of its people, combined with recent steps to tackle stigma, improve knowledge and access to services, means that there are reasons to be optimistic.

Depression in Sudan



by Dr Manhal Zarroug, Psychiatrist

Depression in Sudan is a contentious topic that is a fluid concept; a concept that morphs into more socially acceptable difficulties. It has many descriptions consistent with the diagnostic criteria defining depression, however it is rarely labelled as such due to the stigma attached. In a society that strives to define itself through religion, difficulties experienced in depression are perceived as a 'weakness in faith' or 'tests from God' that must be remedied by prayer and dedication. Depression is also described in varied manners depending on age groups, tribal and ethnic groups as well as rural versus urban areas. Older generations refer to it as 'fatigue from life' with vague somatic symptoms, commonly described as 'a clenching' or 'inner ache' that has no clear cause. There is also the description of 'irritation/intolerance' to describe the social isolation and neglect stemming from depressive symptoms. The younger generations commonly use the term 'stress' and 'worry' for depressive symptoms, and readily link their difficulties to overwhelming social difficulties. Depression is overwhelmingly underreported and undertreated within all age groups, secondary to stigma in most cases. Mental illness is a stigma that is carried by the individual and the entire family, in both urban and rural settings, despite efforts made to reduce stigma by religious leaders and within religious institutions. Traditional healing practices (through faith healers) are common despite on-going attempts to reduce the practice. The use of biological interventions (antidepressants) is prevalent in the younger generations who have access to psychiatric care, however this is primarily in urban areas. Psychological interventions, including CBT for depression, are available interventions that are self-funded, and consequently accessed by a limited portion of the population; again, mainly in urban areas. Deficits resulting from functional impairment in depression are usually compensated by family and social networks, and not overtly attributed to depressive disorder. Depression in Sudan is an unnamed ailment that is experienced and seen, yet rarely acknowledged. Access to mental health care continues to be a challenge to those without access to services or funds.

Depression in Uganda

Depression and Diversity in Uganda: A Therapist's Perspective



by *Eve Achan, MSc Global Mental Health candidate*

Oh no, it shouldn't have been me to suffer through all this; I keep wondering whether the God that I serve really exists; I wonder whether I am worth living in this world especially when I cannot do much for myself and my loved ones; no one understands what is going on with me; I have no proper words to explain how I feel about them; I have gone to church and been prayed for; I have done all the blood tests and nothing was found and yet I feel unhealthy and weak; who could have bewitched me? Oh! What a disgusting world!

(Phrases commonly mentioned by patients)

Since many years back, these statements are still echoed by huge numbers of people in Uganda who are struggling with symptoms of depression, a condition that they do not understand and can't explain to others to make them understand. Depression is among the most common chronic illnesses in Uganda with prevalence rates of up to 26 percent¹. It has a sneaking ability to damage a person's physical, psychological and social wellbeing. Depression is more common among the poor, unemployed, alcohol and drug abusers, people living with HIV and Posttraumatic Stress Disorder (PTSD). Uganda is currently embracing the need to address depression through providing a holistic approach that covers both medical and psychosocial care which include social and economic support. Much as care for the depressed is necessary, the low numbers of mental health professionals in Uganda makes it hard for a significant number of depressed people to get professional attention. Most of them never get access to treatment at all.

Uganda is a typical multicultural country, consisting of 45 tribes with different cultures and beliefs. Description of symptoms of depression vary according to context, in that each culture describes it in their own way. The multicultural setting in Uganda requires therapists to be alert in that regard in order to administer assessments accurately. Sometimes depression may have more than one description by tribe or language. For example words like; *Tuo paa/para (disease of extreme thoughts) among the Acholi tribe, Tam-a-tut (deep thoughts)/Tuo para among the Langi, oburwaire bw'ebitekerezo (disease of thoughts) among the Batooro, Okwennyamila (low mood) among the baganda, Aturur (state of extreme sadness) among the Itesot, Par Madwong (many thoughts) among the Alur* among others. Therapists battle with the fact that they have to employ cultural sensitivity in their daily work while they

¹ Kinyanda E, Woodbum P, Tugumisirize J, Kagugube J, Ndyababangi S, Patel V. Poverty, Life Events and the Risk for Depression in Uganda. PMC. 2011.

endeavour to understand the diverse descriptions of depression based on their client's context. It requires vigilance to understand what the patients mean during assessment and also what to communicate to the patient in the session in relation to their language, and cultures. This is a skill that a therapist will have to pick based on the context they are exposed to. Otherwise, it may not be taught in school since it is difficult to exhaust issues of diversity.

Depression is more common in poverty-stricken areas. If the cause of depression is poverty related, the therapist embarks on effective referral of the patient to other service providers for economic support. However, the chances that the patient will access this support are very minimal, since it's provided mostly by NGOs which run based on targets. This pushes the therapist further to explore clients' capabilities to perhaps start an Income Generating Activity (IGA) to empower them economically. This, as well, must be contextual and culture (including religion) appropriate. The therapist should be well informed of the viable IGAs in the area and whether they suit the patient culturally. The appropriateness of this IGA should be noted, based on the community they interact with as well as their beliefs in that regard. The risks have to be discussed since the idea is aimed at helping reduce on depression. Risks may include choices that may expose them to stigma and failing with their IGA.

As usual, at the end of the sessions, the patients often ask the therapist questions like: "Will I ever get back on my feet and function as I used to? Please tell me, help me out of this." The feeling that the therapist has to give answers makes it seem like they are the determinant of the client's wellness. Yes, that would be the goal but the patient too has a greater role to play in this and this response is often provided to them in a culturally appropriate manner.

To understand depression better in Uganda, it is important to consider context. Professionals should endeavour to know the cultures of the populations they serve so as to provide appropriate services.

Depression in the United States of America



by Erin McCloskey, MSc Global Mental Health alumna, mccloskeyerin@gmail.com

The American Dream is our national ethos and has inspired people from all over the world to establish themselves in the United States. Rooted in the set of ideals in which freedom includes the opportunity for prosperity and success, the American Dream has no room for illnesses, especially one that goes underdiagnosed and overlooked as depression. Environmental factors can contribute to one's risks for developing depression. Today, people across the country are not only struggling to make ends meet, but certain populations (particularly black and LGBT communities) are fighting for their safety.

According to a report by the Centers for Disease Control and Prevention, 7.6% of Americans aged 12 and above had moderate or severe depression from 2009-2012⁶³. People living below the poverty line are nearly two and a half times more likely to have depression than those living at or above the poverty level. In the same report by Pratt & Brody (2014), non-Hispanic black people had a higher rate of severe depressive symptoms compared to non-Hispanic white persons. Both Hispanic and non-Hispanic black populations had higher rates of mild to moderate depressive symptoms than non-Hispanic white populations. With the state of the healthcare system in the United States, one can infer that these populations are not supported to easily access mental health services as it is not only a strain on their income, but also their time and their families' time.

The LGBT community has a higher rate of depression compared to the heterosexual population. Stresses experienced by LGBT youth such as negative attitudes and stigma⁶⁴ put them at a greater risk to experience mental health issues than heterosexual youths⁶⁵. It is not uncommon to read about crimes against transgender people in the news, which shows how far the US needs to go to ensure freedom for all. For so long, research to support this community has been ignored, but recently it is in the developing stages and will hopefully contribute to ways in which detection and treatment can be effective for the LGBT community.

Born and raised in Minneapolis, Minnesota, I have come to know intimately how depression can affect a family. The subculture is influenced by the Scandinavian Americans that settled there in the 1800's. My origins are from Finnish settlers;

⁶³ Pratt, L., Brody, D. (2014). *Depression in the U.S. household population, 2009-2012*. NCHS Data Brief Extracted from: <https://www.cdc.gov/nchs/data/databriefs/db172.pdf>

⁶⁴ <http://www.healthline.com/health/depression/gay#statistics2>

⁶⁵ Centers for Disease Control and Prevention. (2011). *Sexual Identity, sex of sexual contacts and health-risk behaviors among students in grades 9-12- youth risk behavior surveillance, selected sites, United States, 2001-2009*. Extracted from: <https://www.cdc.gov/mmwr/pdf/ss/ss60e0606.pdf>

people who worked hard as farmers to settle and to create their own version of the American Dream. Stoicism and vodka were their preferred coping mechanisms. Over the course of a couple generations, what is now known as alcoholism also took roots in our family tree. It has come in a variety of forms, ranging from moderate depression to perinatal and postnatal depression and to bipolar disorder in conjunction with addiction. Many of these conditions went underdiagnosed for years. Depression does not discriminate. However, healthcare in the US does discriminate who can receive the services they need. The American Dream will remain a cornerstone of our culture, and with it the pursuit of happiness will continue. Hopefully, as mental health with the concentration on common mental disorders gains more coverage, so will access to services to all communities.



Depression in Zambia



by Dr Ravi Paul, Head of Department of Psychiatry, University Teaching Hospital, Zambia, and Dr Subodh Dave, Associate Dean, Trainee Support, Derby, UK

Key facts

Zambia is a sub-Saharan African country with a population of about 15.6 million. Blessed with vast natural resources and home to Victoria Falls, Zambia remains a very poor country, ranking 137th of 186 in the Human Development Index (2014 data). 68% of the population lives on less than USD \$1 a day (2010 data). With a very high prevalence of HIV, life expectancy at birth is mere 48.6 years.

Psychiatric Morbidity

The most commonly diagnosed mental illness in Zambia is depression, alongside other neuropsychiatric disorders such as those relating to drug and alcohol abuse. The risk of mortality is significantly increased by the stigma attached to mental illness, the prevalence of HIV, high unemployment and socio-economic difficulties.

Neuropsychiatric disorders contributed an estimated 4.1 per cent of the global burden of disease in 2008⁶⁶. Amongst the patients attending Psychiatry Clinic at the University Teaching Hospital (UTH is the only tertiary Hospital of the country) the diagnosis of depression was the highest at 34%⁶⁷. The number of patients that present at the UTH Casualty with deliberate self-harm is on the rise and the leading cause for such behaviour is depression⁶⁷.

Prevalence of Major Depressive Disorder (MDD) in HIV patients is 2 to 3 times higher than general population with depression being the most common psychiatric condition in HIV+ patients⁶⁸. Prevalence of depression was 57% in HIV+ patients and 70% in HIV/HCV co-infected patients. Lifetime risk of developing MDD is 2 times greater in women versus men in line with global figures. However, the prevalence of MDD in HIV+ women is up to 4 times higher than HIV-negative women and 3 times higher than HIV+ men.

Alcohol, cannabis, cocaine or amphetamine dependence may contribute to onset or exacerbation of MDD⁶⁸. Patients with untreated MDD are less likely to adhere to medications and keep medical appointments and are more likely to engage in high-risk sexual behaviour and substance abuse.

Untreated depression is associated with increased morbidity and mortality in HIV

⁶⁶ Paul, R., Mwendaweli, N., Kusanthan, T. (2015) *Levels of depression in cancer patients seeking treatment at Cancer diseases Hospital in Zambia*. International Journal of Development Research. 5:11;6052-6056

⁶⁷ Murray, L.K., Haworth, A., Semrau, K., et al. (2006) *Violence and abuse among HIV-infected women and their children in Zambia: a qualitative study*.; J Nerv Ment Dis; 194; 610-5; ISSN: 0022-3018; PUBMED: [16909070](#)

⁶⁸ Mayeya, J., Chazulwa, R., Mayeya, P.N., et al. (2004) *Zambia mental health country profile*. Int Rev Psychiatry; 16;63-72; ISSN: 0954-0261; PUBMED: [15276939](#)

patients. A local study from the University of Zambia suggests that women diagnosed with HIV during their pregnancy were at heightened risk for depression. This study reported that 85% of pregnant women had experienced a major depressive episode and/or significant suicidal ideation. For those who knew they were HIV+ prior to pregnancy, there was significant anxiety about their baby's HIV status⁶⁹.

Another major illness related to psychological distress is tuberculosis with almost a quarter of tuberculosis (TB) patients reporting 'severe psychological distress'. This has considerable public health relevance as this group is significantly less likely to complete the six-month course of treatment and be cured. This 'non-adherence' can lead to antibiotic resistance and developing more dangerous and resistant forms of the disease.

Treatment Pathways

For patients with mental health problems, an estimated 70-80% patients consult traditional health practitioners before consulting with conventional health providers. In 2013, there were only three trained psychiatrists in Zambia. A Department for International Development funded programme helped set up a postgraduate training programme (MMED Psychiatry) and has led to a slow but steady stream of Zambian doctors acquiring postgraduate training in psychiatry. But it remains the case that there is a persistent shortage of trained personnel as well as facilities⁶⁸. The only antidepressant drug available in Primary Health care centres is amitriptyline. Psychological care for patients with depression is lacking. There are no psychologists or counsellors across the health care system, with only a few psychologists at the tertiary level.

Future

World Health Day and World Mental Health Day are important dates in the calendar of the Department of Psychiatry. Over the last few years we have run a psychiatry essay competition for medical students, which has been very successful. The Department also runs a very active undergraduate psychiatry training programme to ensure that the next generation of Zambian doctors are equipped to diagnose and manage a range of common mental disorders, including depression.

⁶⁹ Kwalombota, M. (2002) *The effect of pregnancy in HIV-infected women*. AIDS Care; 14;431-3; ISSN: 0954-0121; PUBMED: [12042089](https://pubmed.ncbi.nlm.nih.gov/12042089/)

The Volunteering and International Psychiatry Special Interest Group

(VIPSIG) was launched at the Royal College of Psychiatrists in 2011. VIPSIG aims to promote and support mental health globally, focusing on the low- and middle-income countries as defined by the World Bank. VIPSIG promotes and supports training and education in the international arena and aims to:

- o Promote volunteer work overseas and expand the population of people interested in this work.
- o Be a voice that will inform the College and serve as an agent in this work.
- o Have a fundraising role in order to develop more volunteer possibilities.
- o Produce a newsletter in order to celebrate volunteerism in the UK and globally.
- o Establish e-groups in order to promote this field by regular discussion.
- o Promote appropriate training materials for volunteers overseas.
- o Explore web-based psychiatry training to assist training sites in mental health.
- o Establish links with non-governmental organisations and diaspora communities.
- o Promote overseas electives for medical students and encouragement of psychiatry as a career.
- o Promote the overseas experience in psychiatry as a desirable attribute for the NHS.

Find our events, newsletters and contact details on the webpage of the Royal College of Psychiatrists at

www.rcpsych.ac.uk/workinpsychiatry/specialinterestgroups/volunteeringandinternational.aspx

Volunteer Scheme at the College

The Royal College of Psychiatrists is committed to supporting mental health care across the world, particularly in countries that are known to suffer from an acute shortage of psychiatrists. The College's volunteer scheme aims to facilitate contact between hospitals, clinics, projects and communities in need of psychiatric expertise and training, and psychiatrists who are willing to offer their time and support.

To register for the Volunteer Scheme of the Royal College of Psychiatrists, please contact Elen Cook at ecook@rcpsych.ac.uk