Experiences from ethnic resource team – inspiration for health and social care services

By Naveed Baig and Stephanie Torbøl

Not all cultures and societies in the world have a tradition of organized pastoral counselling. In many countries crises and grief in connection with illness and death is handled within the family´s own ranks. However, in line with changes in family and community structures as well as the general secularization of society, a lot of citizens are actually living without a strong network to family members and other social relations as for instance local religious communities. This situation is reflected, when professionals in hospitals and other parts of the healthcare sector no longer have the possibility to call for family members or other close relations when patients and relatives have a need for support in connection with illness, death and grief. In many cases, the need for pastoral support and counselling is particularly evident among ethnic minorities, whose social and religious needs have traditionally been somehow invisible in public institutions and services.

This article passes on experiences from the Danish model of establishing a special Ethnic Resource Team with the purpose to systematically make human and voluntary resources available to patients and families in need of grief work in their own language and / or on their own religious and cultural grounds. This also indicates the intercultural guidance of hospital staff.

Experiences from Ethnic Resource Team – inspiration to social and health services

There is a common understanding that ethnic minorities have a large network, and therefore do not need interlocutors or volunteer befriending services. Despite the fact that most do have a social network, it may well be that individuals have a need to speak to a neutral person, who can listen and understand, concerning subjects which they may prefer not to discuss with for example family members. Even if a network can be hugely important for dealing with crises, rehabilitation, caring roles etc., it is not always possible for family members and others to be present with the patient in hospital, in a care home or at home. The nine-to-five work pattern in society affects everyone, and it may therefore be difficult for family and friends to allocate time for visiting their relatives.

Since mid-2008, Ethnic Resource Team (ERT) has received an increasing number of enquiries from the target group. This has in particular been concerning long visits with patients and families. These may originate from the social worker who wants his or her female client to develop a new network following a suicide attempt, as her family has ostracized her - or from the nurse who thinks it would be useful for the lonely man in frequent dialysis to benefit from a volunteer visitor. ERT have had increasing enquiries from parents, who have children with prolonged illness, and have a need for care and support – often from someone with a similar background to their own.

A doctor contacts ERT in relation to a young patient, who for the second time in less than a year has tried to take her own life. The doctor wishes for the patient to have someone to talk to, who could possibly also help with practical matters. A resource person is dispatched to see the patient.

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The patient has no other visitors – the ties to the family have been severed, and she has nowhere to live. The resource person comes to see her twice in hospital and makes contact with her social worker. The social worker is not aware of either suicide attempt. The resource person therefore initiates contact between the social worker and the psychiatric department. When the patient is discharged three days later, the resource person accompanies her to a crisis centre selected by the social worker. Following a conversation with centre staff, for safety reasons, the decision is made to transfer the woman to another centre, with 24 hour staff, where she is allowed to remain.

Imam role

The imam role forms a central part of the work of the ERT, as it addresses the existential, religious and spiritual needs of patients, families and staff. The imam role is a counterpart to the hospital chaplain role. In addition, staff has an interest in receiving training from a hospital imam. The two functions (the general visitation services and the imam role) overlap, but a distinction is made between an enquiry or request for a standard conversation/volunteer visitor and an enquiry specifically concerning an imam. The majority of imam enquiries relate to terminal patients. Quran reading to acutely ill patients and practical help concerning funeral arrangements are the most common causes for enquiries. Further, the role also entails conversations about existential/religious topics and advice on bioethical concerns. ERT has developed a call list of Hindu, Buddhist and Jewish representatives, who can be called upon when needed. The list also includes Shia imams.

At present, the regional authorities or hospitals have no guidelines for employment of hospital imams. Some departments make use of imams on an ad hoc basis, bringing in external representatives (typically from a local mosque) when the need arises. A few major hospitals have a hospital imam on staff, with set office hours and involvement in the running of the organisation on an equal footing with other staff.

The imam role has led to the following positive results:

- Increased confidence among staff, as they have the opportunity to consult and/or involve the imam in particular in relation to religious matters and differences in disease perceptions. Demystification of the imam role through for example explanation of the role in the hospitals at staff introduction. The imam as a colleague. The imam is involved in multidisciplinary team meetings, committees etc.

- A feeling of recognition and safety for patients and families – that their religious representative is visible and available in some of life's most difficult moments.

- Potential for bridging. Patients/families listen when the imam is involved in the patient pathway. For example, the imam can explain pros and cons of a stay in a nursing or care home to a family who may have a very biased view of care homes and the care home culture, and may lack an understanding of why they are being referred from the hospital to a care home.

Example of interdisciplinary cooperation: a psychologist involves a hospital imam in conversations in the clinic with a mentally ill and suicidal Arabic head of a family in his mid-forties. The three gather in the psychologist's office, and after the psychologist's introduction, the imam talks to the patient about his existential problems and his view of God. The man is feeling isolated and has lost his will to live. He feels distanced from the rest of the family, and feels guilt at not being able to be there for them in the way he feels he should. The patient is very introverted. The man expresses the sentiment that "if Islam did not forbid suicide, he would have taken his own life a long time ago."

Tangible tools for staff

We have to treat people the same, and therefore we have to treat them differently, because people are different. Staff wants practical tools for solving practical tasks relating to all aspects of their work – including the challenges they may face when interacting with ethnic minorities.

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At almost every training session for health and social care workers, a need for tangible tools has come up – specific methods or tips, which can help staff in their day to day work. Sometimes, staff members ask culture specific questions, such as "How would you deal with this in Somali or Turkish culture?" Overall, generalisations should be avoided. However, there are some areas where it is possible to draw some general conclusions (for example that Turkish people do not eat pork because they are Muslims), but there are also areas where it would be professionally indefensible and unethical to generalise (such as Somalis are addicted to khat). Intercultural communication is, in our view, the best approach for successfully dealing with misunderstandings and misconceptions which can arise in a department. This avoids any unnecessary generalisations.

There is more than one reality

Two people, who share the same experience in the same time and place, will not necessarily experience this in the same way. Our perceptions are filtered through different filters, such as our senses, experiences, beliefs, prejudices, knowledge, faith etc. All these filters combine to draw our personal map of the world and of life. As such, two patients admitted to the same hospital and treated for exactly the same condition by the same staff members, may well have widely differing views of the treatment pathway, and may therefore react in different ways. If communication is to be equally successful with both these patients, it may be useful to recognise and use as a starting point the experiences of the individual, and to examine the map which is the foundation for this experience.

A nurse enters the room of a female patient about to undergo surgery, to explain the procedure. The patient's husband is present. The nurse initially greets the patient by shaking her hand, but as she turns towards the husband he retracts his hand and states that he does not greet women. The nurse explains that in her culture, this could be taken as a sign that he does not respect her as a woman. The husband and the patient then explain that it is an element of their culture and tradition that a man does not greet a woman by shaking her hand, and that in their country of origin it would in fact be viewed as a sign of lack of respect for the woman if he were to do so. They end up sharing a laugh over the matter.

What the nurse did in this situation was in fact to explain to the couple how she interpreted the husband's reaction from her own world map (her cultural codes) without attributing to him an intention to offend her, but leaving it open to him to explain the reasoning for the act based on his map. All in all, this communication may have taken three minutes, but the result is that the treatment can be initiated in the best possible way, with a shared understanding and laughter. There may not always be time or energy to have such a chat, but if nothing else, this mindset can contribute to avoiding unnecessary judgement or offense on the wrong basis, sparing the participants (patients and staff) the negative mood which this could cause.

Treatment culture

One of the filters which often shape our perception of a situation is, of course, culture. If we examine specifically treatment culture, there is no need to travel far to discover marked differences in the way in which a doctor treats patient symptoms, or in the expectations people have of the doctor. At a doctor's visit in France for example, it is almost guaranteed that the patient will leave with prescription, whether the complaint is a minor cold or some type of infection: nasal spray for blocked sinuses, throat spray for throat problems, powder for stimulating a cough etc. As such, a French patient may well feel let down or not taken seriously, when a Danish doctor sends him home empty handed with an advice to drink chamomile tea or go to bed, or worse, with advice to exercise more.

Neither is necessarily right or wrong. Both are acting and reacting from their respective cultural maps, and based on what this tells them about good treatment in their respective cultures. Again, it is therefore important that the doctor investigates what may be causing the patient to feel unsatisfied, and explain why she is choosing a different treatment path. In this way, the patient can avoid draw-

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ing the conclusion: "The doctor is sending me home with no medication – as such she has let me down and considers me a hypochondriac" or "Danish doctors are incompetent", and the doctors avoids thinking "the patient is unhappy, so I must be a bad doctor" or "French patients are arrogant". Instead, they are able to develop a joint understanding of the issues, using dialogue.

Ethnic pain

Other cultural filters which may be relevant in communication with ethnic minority patients, is disease perception, body perceptions and the way in which pain is described. How can pain be expressed verbally?

The "ethnic pain" is an expression which has spread in hospital culture – especially in departments under significant time pressures. Typically, it is an issue of patients who express and describe their pain in a way which the staff are unaccustomed and are unable to interpret – either because they are viewed as being very demonstrative in their suffering, or because they verbalise it in a language which is less clinical than staff are accustomed to. For example, the expression "a burning sensation in the body" has surfaced on several occasions during training sessions held by ERT – primarily from hospital staff.

In actual fact, this is an issue of communication, which is apparently difficult to solve – partly because staff lack the time, tools and energy to tackle it, and partly because the weakness and alienation increases the fear and lessens the communication skills of the patient.

"Personally, I do not like the expression 'ethnic pain', but I use it because we know what we are talking about then", a nurse honestly admits during a training session. She most likely feels that she can then put words to what she does not understand, at that being able to verbalise the incomprehensible gives a sense of control, because it provides an opportunity to minimise it and thereby prevent it from affecting one's work too much. This is a natural defence mechanism, which protects against being overwhelmed by frustration and paralysed by impotence, and can be the first step on the way to addressing the problem. Having a word or an expression for something, means you can begin to discuss it and make the problem visible. The most important thing is for the problem to actually be addressed. Otherwise, such expressions may act as blinkers, covering up the core of the issue. Ethically, this is unworkable in a hospital – the patient is weak and alienated, and as such, it is the responsibility of staff to tackle any communication problems.

It is crucial to move the focus from "it is the unfamiliar which is causing problems" to "we lack communication tools". From the subject to the relation and from the identity (he is that way) to the behaviour (he acts that way), instead of jumping from behaviour to identity (he is evil because he never smiles).

Intercultural communication

Intercultural communication is a term for the communication which takes place between people with differing cultural backgrounds in a given social and cultural context (Jensen, 2001, p. 45).

Culture is a very broad and flexible concept. Culture includes habits, faith, art and other results of human activity in a specific group of people during a specific time period. As such, culture is something we all possess – even if we are not always conscious of it. The reason why there is a need to focus on Communication is partly that staff themselves feel that a lack of language skills is the main challenge in their interaction with ethnic minorities (and as such, non-verbal communication can be necessary) - and partly that there is a tendency in the health and social care sector to view communication related problems and uncertainty as caused by the cultural and religious background of the individual. For example, if there are some individuals in the patient's family who speak in a certain tone or have a different kind of eye contact than staff are accustomed to, this will often be attributed to an unfamiliar or distant culture – as if one has never before encountered individuals with a different tone, different gesticulations, different facial expressions etc.

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There is a tendency to forget that people are different, and that their education, childhood, networks, experiences and so on can affect the way in which they address staff.

Intercultural communication provides staff with the confidence to engage in an "equal dialogue" and to tackle difficult topics, allowing them to get to know the patient better and provide higher quality care and treatment. This also means that – once the trust has been established – it is possible to relate difficult messages without anxiety. It is the uncertainty and anxiety, which may disrupt communication to an extent where attempts at communication are abandoned altogether. The Roman philosopher Seneca (ca. 4 BC – AD 65) said: "It is not because things are difficult that we do not dare; it is because we do not dare that they are difficult". Making an effort and paying attention to things which may be different (such as a different disease perception), and an appreciative world view can all help enhance communication – even if sometimes people do not even speak the same language. This does not mean that you have to agree with the lifestyle, behaviour etc. of the other person, but that the process, exchange and dialogue are the main points of interest in the encounter. Culture and the unfamiliar are part of the framework around the communication, but the individual as a unique human being must be at the centre, not culture or religion – even if this can hold significant importance for the individual.

Religious assessment

"Religious assessment" relates to questions about spiritual needs and concerns for patients/families. Religious assessment is common in the psychological/therapeutic field – in particular in the US – and is becoming more and more widespread in other Western countries. The purpose of a religious/spiritual assessment is to help counsellors to decode the possible relation between the spirituality and the patient's problems (Frame, 2003). Staff is encouraged to employ a neutral and inclusive language when undertaking this type of assessment, for example "religious community" instead of "church", "religious/spiritual leader" instead of "priest", "higher power" instead of "God" etc. Religious assessment is not about agreeing with all life views/ religions, but rather concerned with ensuring that staff discovers and makes use of the spiritual resources of the patients themselves, in order to promote their appetite for life – without judgement and stereotyping (see also the website about palliative care, www.endlink.lurie.northwestern.edu, developed by the Cancer Centre and Northwestern University (US); this is a resource page, which provides a multidimensional introduction to topics relating to dying patients and their families – primarily for hospital staff who work in this important area).
Other purposes may include:

- That religious and spiritual questions are used as a resource for patients.
- To establish the degree of health and pathology in the patient's beliefs, as religion and spirituality may well be linked to improved physical health, emotional wellbeing and so on (Frame, 2003). Religion and spirituality may also have a negative influence, and can harm the patient. This can involve – according to Richards and Bergin (1997) – demonic possession, overly focusing on one's sins, spiritual depression, panic over religious themes, constant repetitions of specific religious acts etc.
- To uncover religious and spiritual concerns, which may be causing psychological problems for patients, for example if children whose relations have subjected them to abuse and isolation may question a caring and protective God later in life.

Richards and Bergin (ibid.) suggest nine dimensions of religiosity, which should be covered with patients with mental illness, in order to build up a picture of the religious and spiritual domains. The domains which are of relevance to health and social care staff to work on in interactions with ethnic minorities are set out below. This assessment should not necessarily be employed therapeutically, but can also be used as an icebreaker – in interactions with somatic and psychological patients and their families – allowing staff to have open conversations with the individual about faith and life. It is important

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that staff is clear beforehand about their own beliefs.

- ***World view***. Is there a belief in a God or higher power? What is the view of the world, of evil and how much free will individuals have to influence their destiny? If there is a belief in a higher power, what type of power is this, and what does it mean for the individual? Patients who believe in a merciful and forgiving power often have a higher sense of self worth (Richards & Bergin 1997). Patients who for example have a belief in a punishing, vengeful or impersonal power may have less hope, and this can be useful for staff to be aware of when interacting with patients.

- ***Degrees of faith***. Is the faith practised actively, or passively? Which religious aspects are taken seriously? An answer from a Muslim may be that he or she abstains from alcohol and pork, but only attends prayer a few times a year for holidays. There will be others who do not practice their religion at all and do not wish to discuss religion. These patients will therefore not be able to make use of religion as a resource or support.

- ***How do patients solve their problems?*** It is important for staff to know what approach patients take to problem solving. If this relates to specific religions or theological questions, Richards and Bergin (ibid.) suggest involving a spiritual leader from the given faith. Experiences show that staff who understands the religious beliefs of their patients finds it easier to enter into dialogue and ask detailed questions. A young couple who had a stillborn daughter in a Danish hospital (where they were visited by an Imam), were very pleased to discover that the nurse knew that according to Muslim faith, their daughter was to be interred, and that the nurse was aware of the rituals involved therein. As such, the nurse was able to have a caring and supportive conversation with the couple, discussing the burial and the coordination and arrangements. Assessment of terminal patients is of a different character, but is highly important: is it ok to discuss death? Do you believe that the moment of death it predetermined? What is your relationship with death? What happens after death? Do you wish to discuss the details with someone from your own faith community?

- ***Values and lifestyle balance***. When "values" do not align with "lifestyle", this may also lead to feelings of shame and guilt. In his book, Frame (2003) provides an example of a Christian-Mormon woman aged 23, who sought help for depression with a therapist. After some general questions about her life, the therapist queried her religious and spiritual life. The women explained that she was a practising Mormon, and used to be involved in missionary and other church work. However, when she started university, she felt a sense of guilt that she did not have enough time for church work. As she could not live up to her self-imposed demands, she became ill. The therapist alerted her to the fact that her need to be "perfect" was related to her depression. If the therapist had not queried her religious life, the main cause of her suffering would have been much more difficult to determine.

The position of individuals and families, membership of a faith community, the role of faith in one's life (past and present), the role of God (or a higher power) in illness processes, the degree of joy and peace from religious and spiritual practices etc are questions which are brought to the forefront by religious assessment (Frame, 2003). If the individual observes religious holidays such as Ramadan, Yom Kippur etc, then it would be straightforward to discuss these holidays and their significance to the individual.

Other detailed questions could be: are you aware of any religious or spiritual resources in your life which you may be able to draw on to overcome your problems? Do you believe that there may be religious or spiritual causes which have contributed to your conditions? Do you wish for your representative from the institution to contact your religious/spiritual representative, if you feel it may be beneficial to speak to him/her? Do you want to consider discussing religious and spiritual issues with your representative in the institution, if this may be helpful?

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In the future there will be a need – as experiences have illustrated – for resources and guidelines concerning ethnic minorities in hospitals and healthcare institutions in Denmark and the other Nordic countries. These guidelines can provide security and strength in vulnerable situations, where all may appear lost. For this group, there is a real care need, which does not just relate to admission and treatment, but also to the time of discharge, where the patient will be returning to their everyday life.

Literature

Cullberg, J. (1993): *Krise og Udvikling*. 4. Edition., Copenhagen, Hans Reitzels Press.

Frame, M.W. (2003): *Integrating Religion and Spirituality into Counselling*. Pacific Grove, CA: Thomson, Brooks & Cole.

Jensen, A.D.R. (2001): *Interkulturel kommunikation*. In: Andersen, J.H. & Jensen, A.D.R. (eds): Ethniske Minoriteter: Kulturmøder i sundhedsvæsenet. Copenhagen: Munksgaard.

Kristiansen, M (2009): *Ekstern evaluering af ERT.* Institut for Folkesundhedsvidenskab, Afdeling for Sundhedstjenesteforskning, Copenhagen University.

O'Connor, J. (2007): *NLP i teori og praksis*. Copenhagen: Aschehough.

Richards. P.S. & Bergin, A.E. (1997): *Casebook for a Spiritual Strategy in Counseling and Psychotherapy*. Washington, DC: American Psychological Association.

Sundhedsstyrelsen (2007): *Sundhedsprofessionelle i en multikulturel verden*. Copenhagen: Sundhedsstyrelsen.

Online

Endlink.lurie.northwestern.edu (EndLink – Resource for End of life Care Education)

Ikas.dk/Den-Danske-Kvalitetsmodel.aspx (Den Danske Kvalitetsmodel, developed by Institut for Kvalitet og Akkreditering i Sundhedsvæsenet).

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Depression, Women and Culture

By Birgit Petersson

In different cultures great differences are found in the depression rate and women report about depression 2-3 times more often than men. There has been an increased extension of especially the American diagnostic manual of mental disorders, DSM, which does not include cultural differences. The historical differences, the change in the diagnostic manuals and the consequences of these, are discussed. The knowledge from research has changed in such a way that the importance of social factors have been more obvious. The research methods have become more valid, even though these still do not, or only to a small extent, include the cultural differences. There are, among other things, great cultural differences in the societies about which feelings that are accepted socially for men and women.

Introduction

There is an increasing need for awareness of the cultural differences when people from different cultural backgrounds request support for psychological or somatic problems. This is a need which has grown in line with the internationalisation which has taken place over the last few years. In fact, this need has existed for many years in societies with high immigration rates, such as the US and UK, but it has often been ignored or there has been a lack of willingness to acknowledge the importance of cultural differences for the development of illnesses.

There is now also a growing recognition that it is not possible to transfer a Western diagnosis system to other, non-Western cultures without issues. Still, not least the American diagnosis system DSM seems to be going from strength to strength across the world. Why? I will not examine the deeper underlying explanations in this context, but will point to the pharmaceutical industry and their overwhelming interest in a Western diagnosis system. With such a system, the doors are opened for the medicalisation which has taken place in Western psychiatry since the 1950s to be expanded to the rest of the world. This is illustrated, amongst other things, by medical conferences, which are often financed by the pharmaceutical industry, where they also often invite groups of psychiatrists from third world countries, which would never be able to finance travel and lodging themselves.

There are, of course, also advantages to having a joint diagnosis system. In research for example, it can be very difficult to compare studies, because different diagnostic tools have been employed. As such, it would be an advantage if we could be sure we were referring to the same concepts when for example discussing the frequency of depressions. But what if this is an illusion, and we were in fact not referring to the same thing? Or are merely discussing a minor part of the problem, because it has different modes of expression? Thus, the important question is: Is it really that important what the culture in question is? Are the major disease types, for example depression and schizophrenia, not the same no matter where in the world they occur? If not, what influence do cultural differences actually have?

In this connection depression is a good example for illustrating cultural differences and their importance, which can be used in both research, prevention and treatment contexts.

Diagnoses

There are significant cultural differences in the American and European diagnosing practices. The World Health Organization WHO has selected the European diagnosis system ICD for its use, while the research community to an increasing extent are

using the DSM system. The European system has its roots in the work of the German psychiatrist Emil Kraepelin during the late 1800s. The American system is based on the work of the Swiss psychiatrist Adolf Meyer. He emigrated to the US, where he worked as a professor in Baltimore. His overarching view was that depressions were caused by the individual being maladjusted in the environment, while Kraepelin felt that development of for example depression was due to endogenous factors.

Even though there has since been a partial alignment of the two diagnosis systems' criteria for example for depression, there are still marked differences. In DSM, it is required that the diagnosis of depression can be applied no sooner than two months after a serious loss such as a bereavement. Until then, it should be treated as a grief reaction. Comparing the diagnosis criteria, there is also a tendency to a more condemnatory attitude in ICD, for example illustrated in the criteria for mania. Whether there is a difference in how the diagnoses are employed in practice, and whether this also reflects a more humanitarian attitude in American psychiatry, is uncertain.

Western psychiatrists are aware of the difficulties relating to diagnosing. In an overview of the modern disease classifications, The Danish psychiatrist Bech (1993) points to the difficulties of the depression diagnosis by quoting Wing: "to diagnose is first to observe a condition, and then to create a theory of it". In the latest edition of DSM, DSM-IV, American Psychiatric Association (1994) emphasises that there are cultural differences in the expression of depression, while this is not the case in ICD. The increasing degree of somatic symptoms the closer you get to the Mediterranean countries, the Middle East and Latin America, is mentioned. As is the understanding of depression as being caused by demons, present in for example some African countries.

Taking a historical view of the development of diagnosis systems, it is possible to identify distinct phases based on experiences from clinical work and later on from research projects. Originally, diagnoses were developed based on clinical observations, and not until the mid-1900s did population studies begin to become included. This meant that diseases in the psychiatric "infancy" were described from severe clinical and often hospitalised cases. Only later less debilitating diagnoses outside of hospital were identified.

Research projects which can be referred to as phase I studies include clinical studies with structured diagnostic systems (Petersson and Kastrup (1995), Prior (1999), Romans (1998)). Amongst the best known are Stirling County and Manhattan-Midtown studies, but the Samsø study from Denmark can also be counted amongst them. In these studies, one finds a high frequency of mental illness on the population, but very few were in contact with the treatment system. In the majority of studies there were marked differences between the genders. In the Stirling County study for example, 66% of women versus 45% of men reported psychological stress.

In phase II studies, diagnostic interviews were employed with different scales, such as the semi structured PSE. These studies have been undertaken in a large number of countries, and show marked differences in symptom reporting between countries and between genders. Examining interview schedules, it is often apparent that there are far more questions relating to symptoms which are more common in women, for example anxiety, phobias and depression, while the more externalised and antisocial symptoms are underrepresented. As such, there is an inherent gender bias. Correcting for example for alcoholism and psychopathy, gender differences overall are far less marked. However, examining differences between countries, then these remain significant, for example 7.5% of Dutch women have mental health problems judged against PSE compared with 22.6% in Greece and 27% in Uganda. It is important to keep in mind that national differences in accepted modes of expression are not accounted for here, and as will be illustrated based on varying acceptance of expression of emotions, these differences are not due to actual illness. Holland is interesting in this context, as there is only a very small gender difference. 7.5% of women versus 7.2% of

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men report mental health problems. In Greece the figures are 22.6% and 8.6% respectively.

Phase III studies are larger epidemiological studies such as the ECA study, which also employs diagnostic interviews, but where these have been adapted to ensure a better balance between the number of symptoms for men and women respectively. The study still shows an overrepresentation of anxiety, depression and phobia in women, and antisocial behaviour and abuse in men. The frequency of depression is two or three times higher in women, but in the overall level of symptom reporting, the gender differences have been almost completely eradicated. A large number of such studies are now underway around the world, but even though some rating scales have been validated in different cultures, it is important to question what is actually being measured. For example in Arabic countries depression is used exclusively for bereavement, while what we may refer to as depression is described for example as an "oppressive mood" (Hamdi and associates 1997). In other countries the differences in modes of expression are even greater, not least when considering psychosomatic symptoms.

Gender differences and prevalence

Almost all studies indicate that women, when ignoring the manio-depressive diagnosis, develop depression two or three times more frequently than men. Some studies indicate that the gender ratio may be somewhat different amongst the very young, for example a seven year follow-up study by Ernst and Angst (1992) showed that young men developed depression almost as frequently as women. But while the depression rate among the men dropped with age, the rate among the women remained high. In the younger age group mental illness in women is often characterised by eating disorders, and the depression is often a reaction to the eating disorder. The proportion of women with depression in Western countries peaks in the 30-45 age group, contrary to what might be assumed, as the use of antidepressants increases with age.

In an observational study of 18 years old men and women, Gjerde and associates (1988) found that men with depression were more aggressive and expressed a sense of alienation, while the women were more introspective with feelings of guilt and low self esteem. Interestingly, a concurrent self-reporting study showed that the men experienced guilt feelings and low self esteem, while the women reported aggression and alienation. Taking account of the gender socialisation patterns present in Western countries, this reflects the gender role manifestations and expectations for men and women respectively. Several authors have pointed to the fact that women in many ways can be said to be brought up to be depressed. Where boys to a larger extent are taught to be independent and extroverted, women are taught to be intimate and dependent. Despite the fact that these are gender role stereotypes, there is no doubt that the image of "the rational man" and "the emotional woman" are expressed in a number of studies.

Based on this observation it is possible to question whether depression in men and women should be expected to express itself in the same way, given the different expectations of the behaviour of men and women. If depression for example is caused by a strain, would it then take the same form of expression in men and women? Would "depression" in men not be characterised by greater aggression or even violence, in contrast with that of women which is characterised by a more internalised behaviour? Today, some researchers believe that antisocial behaviour, violence, abuse and criminal behaviour in men should be viewed as a expression of depression, caused by the differences in socialisation.

For me, this perception means that in future, it will be necessary to examine reactions to strains and tensions rather than actual disease – and possibly separate some disease related issues, for example the manio-depressive psychosis – while other issues can more advantageously be considered reactions to life events and strains, even if this has different manifestations depending on the strength of the individual prior to the event. The expansion of the diagnoses which has taken place in particular in the DSM system in the latest editions is certainly not appropriate.

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Hypotheses on the development of depression

Explanations of why depressions arise have taken varying forms across the last centuries. As with the large population studies, they follow a historical development which is parallel to the research tradition prevalent in the different periods. There are two major questions: Why are depressions developed at all, and why are they more frequent among women?

Among the earliest explanations for the overrepresentation of depression in women are the biological, where depression in women is attributed to hormonal differences. An example of this is the myth of the accumulation of depressions in menopause, which has never been confirmed in population studies. On the contrary, a decrease in depression with increasing age has been found. The myth was so persistent that is was only removed from teaching materials and diagnosis lists during the 1990s. Another is the myth of depression prior to menstruation. Whether these exist or not has caused great disagreement, most recently in connection with eh development of DSM-IV. This disagreement resulted in menstruations problems being included in the diagnosis descriptions as Premenstrual Dysphoric Disorder (Gold and Severino 1994). Depression is one of the main criteria for this diagnosis.

Post natal depression is also controversial. That some women develop depressions cannot be disputed, but there may be good reason, as I will discuss in more detail later on, to question the prevalence and the causal factors. More recent hypotheses which have caused a great deal of interest includes Seligmann's hypothesis of learned helplessness. Seligmann proposed this hypothesis after showing that rats (and later other test animals) developed apathy when they were exposed to a number of challenging strains, such as obstacles to obtaining food. This apathy persisted even after the obstacles had been removed. Later on, Seligmann and associates have continued this research, and have shown that resignation in relation to tasks is more often present in the behaviour of women than that of men, leads to depression. In recent years this type of research has been developed further, and has lead to research into health maintaining factors. Seligmann has lead some of this research, but perhaps the best known is Antonovsky (1991).

The thirds explanatory model is the psychosocial. It has long been known that the worse the socioeconomic conditions, the greater the risk of mental illness. However, in relation to depression, for a long time the view was taken that conditions were different, in that admissions were often of women in higher socioeconomic classes. Perhaps for this reason, the study of conditions among groups of English women, but Brown & Harrison (1978), came as a shock to some, and a revelation to others. Brown and Harrison (1978) found a number of risk factors in relation to the development of depression: low social status and young children living at home, loss of a parent in childhood etc. However, they also established, by comparing conditions in an island community with those in the urban setting that social networks can act as a protective aspect against some of these risk factors.

Jack Bryø Jensen and I (1982) undertook a corresponding study at almost the same time, only this was focused on pregnant women, who were followed through their pregnancy and until six months after birth. Half of the women lived in Copenhagen (the Capital area, edit.), the other half in Holbæk (a smaller urban society, edit.). There were marked differences in the development of mental health problems including depression. Again, the social networks and good living and working conditions in the smaller town acted as protective forces. The conclusion, which may be surprising to few people today, was that social factors were and are of great importance in the development of mental illness.

Social psychiatric research has pointed to the differences between the social lives of men and women as possibly the main explanatory factor for the gender differences in prevalence of depression. Almost regardless of how men and women are compared, their different life conditions are apparent. For an example, female doctors tend to be far more strained than male doctors, and they have a

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high suicide rate compare with society in general (Korreman 1994). The fact that the majority of male doctors are married to a partner with a shorter education than themselves, and that a proportion of these partners either work at home or have reduced work hours, affects the overall strain on the families. It could be argued that everything seems to indicate that men and women come from two different cultures, no matter where in the world we turn our eye. More recent studies, where the social experiences of men and women are approaching one another, do appear to even out the differences in the prevalence of depression. And prevalence of depression also increases in groups which are socially vulnerable (Romans 1998).

Cultural differences

One of the criteria for depression in Western countries is a feeling of guilt. However, there are indications that this is specifically related to Christian culture, which can also be described as a highly individualistic culture. Being raised in a Muslim culture, this is characterised by shame, and the external prestige in interrelations between people is highly conspicuous. These societies are therefore much more affected by ideas and perceptions about honour and shame (Benedict 1979). This must be included in our understanding of mental health problems - as well as our understanding of the problems which can occur within families, where some may feel or be let down and/or betrayed, and in the way in which one may seek to solve such conflicts (Petersson 1999).

This is not just the case in Muslim culture, many Eastern cultures, such as the Japanese, are also highly affected by shame. This can lead to hiding the illness of a family member, or rearticulating it with other, non-stigmatising, concepts. This may be a contributory factor in the greater reporting of psychosomatic symptoms in relation to depression, as these psychosomatic symptoms to a lesser degree lead to judgements from society. In such cultures, one may also be less likely to report on any issues, as the external perception, not just of oneself but also of the entire family, is being endangered. Hamdi and associates (1997) mention expressions such as “my heart is poisoning me”, “ “as though boiling water is poured on my back”, as examples of expressions of depression in their study or Arabic people.

In Buddhist culture, the fate of the individual is the defining factor for illnesses, including depression. Depression is not an illness, but an occurrence caused by previous bad actions. This belief is closely related to the belief in reincarnation. Examinations of people from Buddhist cultures show that this belief in destiny appears to protect people, so that they can attribute a meaning to events which does not lead to feelings of guilt or shame, contrary to what we find in Western cultures. Studies of for example Tibetan torture survivors show that, despite symptoms of strain such as flashbacks, there is a distinct lack of depression, avoidance and repression (Lützer and Mathiasen 1998). The belief that the individual is merely being affected by fate is also present among Muslim groups, and some elements can also be found in European culture, for example on the idea of hubris and nemesis.

In certain African cultures, depression in people is attributed to external causes, and this reasoning appears to counteract internalisation of feelings which could lead to guilt and shame. In other cultures grief is viewed as a spiritual experience (Eisenbruch 1990), and in some countries it is common to experience hallucinations in connection with severe losses, symptoms which in our culture will mostly be regarded as signs of a serious mental illness. This does occur as a temporary consequence of strains in our culture, for example many people may experience that a loved one is still in the room, long after they have passed away. One of the women I followed for the pregnancy study experienced a period of about a week’s duration (roughly a month after the birth), where she heard the child crying constantly, despite the fact that it was not crying and was often sleeping soundly when she checked on it.

Cultural differences in permitted feelings

If it is viewed as very shameful to express certain feelings in a given culture, these feelings may not be present, or only present themselves

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very rarely. Some feelings are experienced but not expressed. As such, as Kirmayer and associates (1998) state, it is not possible to conclude that these feelings are not in fact present. For example, it is far easier for Vietnamese people to express feelings in anonymous questionnaires and especially in a foreign language. This is a problem I have often encountered in a slightly different incarnation, in that I have for a number of years participated in interpreter training sessions, where a new interpreter would translate for me, while a practised interpreter listened in an corrected any mistakes. Without fail, shameful events were not translated, and even the experienced interpreters would admit that they often found it difficult to translate items which were straining for their own culture.

Not least in Japanese culture, there is a ban on expression unkind feelings, at least in the public space, something which does not go away, even when people move to a Western country. Otherwise, there are great differences in the feelings which are permitted in different cultures. Fischer and Manstead (2000) have examined gender differences in feelings in different cultures, and found that, in line with the issues previously discussed, there is a connection with whether the culture concerned is individualistic or more collective. As such, fear seems to be less prevalent in men in collective cultures, both when compared to women from the same culture or with men and women from less collective cultures. The same is the case for shame and guilt. With regards to melancholy and disgust, women from individualistic cultures score the highest. It appears that men in Western cultures are encouraged to avoid settings which can undermine their status as individual men, men with "control over their emotions". The authors also show that these differences are greater, the more individualistic a country is. Even within the Western world there are significant differences, and as such, the US, Sweden and Holland score highly in relation to individualist, while for example Poland, Portugal and former Yugoslavia score lower. In other continents too, it is not possible to simply transfer norms from one country to another; there are significant cultural differences in the "permission" to express emotions and the freedom to be independent. This does not involve a judgement of which is best, but is simply to point out that there are differences. Even if we in the Western world believe that individualism provides great freedom, there are advantages and disadvantages to both. Madden and associates (2000) have examined depression and anxiety in relation to gender, and found that when comparing these with the "permission" to express emotions, that this in the individualistic counties – that is, primarily North America, Western Europe, Australia and New Zealand – is a contributory factor to keeping women in inferior positions, even if they are otherwise able to participate actively in the economic and political spheres. Whether these gender differences will change, as there are indications they may, when men and women are analysed based on the same social conditions, is an interesting issue to follow in future. At present, I am analysing - as well as possible - stress among men and women with identical professional groups and same social conditions, ie people who are being examined to establish any actual gender differences. Initial results indicate that women, in all of the professional groups involved, report experiencing more stress than men. However, men with partners who have longer educations than themselves are the most stressed. This may indicate that it is difficult to be socialised to being a real man, when one's female partner all of a sudden possesses and repræsents the traditionally masculine values within the family: high status, high income etc. But it may also show that the care for the family, which women traditionally undertake through double working, is now becoming double work for the man, with the accompanying increased risk of development of depression and other illnesses, and the latest research appears to show.

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