Depression and anxiety in the developing world: is it time to medicalise the suffering

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It stands to reason that when life's circumstances are harsh, people will feel stressed or depressed. Poverty, violence, and infectious disease, including HIV/AIDS, in the developing world, and in the lower socioeconomic strata of the developed world, lead to anguish and despair.[1] Such responses can readily be understood as normal responses to abnormal circumstances. There has perhaps been a tendency to regard this kind of mental suffering as a meaningful response, and therefore as a phenomenon that lies on the periphery of medicine proper. The prominence of communicable disease in poor regions and classes may further marginalise the medical status of psychological symptoms.

It is time for a change in perspective. Poverty and depression are closely linked,[2] and violence can lead to post-traumatic stress disorder and other psychiatric diseases. Nevertheless, depression and anxiety disorders, as well as resilience to these conditions, are phenomena that cut across rich and poor countries and classes. Depression and anxiety disorders are associated with suffering, but they are also underpinned by characteristic psychobiological dysfunctions. And they respond to specific medical interventions.

Support for a change in perspective is found in a range of data, some from recent studies. First, there are data on the prevalence of and disability associated with depression and anxiety disorders in the developing world. The WHO World Mental Health Survey Consortium,[3] in the largest and most sophisticated cross-national survey of psychiatric disorders so far, recently confirmed previous work that, worldwide, mental illness is highly prevalent, associated with significant impairment, and often untreated. Undertreatment is particularly problematic in the developing world. The Global Burden of Disease study[4] found that even though the share of disease burden from depression is lower in the developing than in the developed world, depression in 2000, as in 1990, caused the largest amount of non-fatal burden worldwide.

Second, there is increased understanding of the psychobiological underpinnings of depression and anxiety disorders. Some of this knowledge is consistent with a view that depression and anxiety is a normal defence that has adaptive value.[5] But research also documents clear deficits in mood and anxiety disorders. Post-traumatic stress disorder, for example, is characterised by allostasis of the endocrine system, and by reduced volume of the hippocampus.[6] Conversely, there is growing understanding of factors that play a role in resilience to such deficits, despite exposure to adversity.[7]

Third, there are data on the efficacy of specific medical interventions, not only in general but also in people living in the adverse circumstances of the developing world. Patel et al,[8] for example, found that the antidepressant fluoxetine was superior over the short term to both placebo and counselling for depression in primary care in India. Bolton et al[9] showed that interpersonal therapy for depression was better than treatment as usual in Uganda. Modest interventions can have a substantial effect on symptoms and impairment in the developing world.[10] Cost-effectiveness analyses support the value of treatment,[11] although additional research is needed to maximise effectiveness in the developing world, where cultural and health systems might affect the applicability of findings from efficacy trials.

Are there risks to medicalising suffering? Philosophers and sociologists have warned against the overextension of the medical gaze.[12,13] Certainly, if we focus only on pharmacotherapy and psychotherapy, we run the risk of failing to address key societal risk-factors for depression and anxiety (eg, poverty, gender inequity). There are no good data that conceptualising depression and anxiety as medical disorders detracts from such broader efforts. Nevertheless, creative interventions other than pharmacotherapy and individual psychotherapy should be studied. In the developing world, various kinds of community programmes might prove effective.

At the same time, a medical perspective has potential advantages. For one thing, such a perspective is consistent with an evidence-based approach to problem-solving—adopting evidence-based health policies and medical interventions seems rational. Such a stance potentially avoids some of the stigma of suffering. The Global Forum for Health Research[14] argues that health indicators are more than mere indexes of suffering: they can serve as key targets for economists. Focusing on such indicators is a particularly efficient way for governments to invest.

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Patient in makeshift mental home chained to table
Patients are chained to prevent them running away (Monrovia, Liberia, Aug 29, 2003).

Some basic changes will be needed if we are to take this medical turn. Much as doctors needed to be trained to diagnose depression in patients with cancer or stroke (despite the understandability of being depressed in such conditions), so practitioners in the developing world will require training to screen for depression and anxiety disorders (despite the ubiquity of such diseases).[15,16] Diagnostic criteria might require updating. For example, criteria for generalised anxiety disorder state that the worry must be excessive, resulting in an underestimation of symptoms of generalised anxiety disorder in a stressed community.[17] Parallel efforts to increase mental-health literacy in communities are crucial.[18]

Further, policy initiatives are required that encompass reduction of societal risk factors and improvement of access to care for people with depression and anxiety disorders. Sustained interventions are needed to encourage the collaboration of international and local governments as well as private organisations to decrease the stigmatisation of psychiatric conditions, to increase the number of mental-health practitioners, and to make drugs available.[19,20] In HIV/AIDS, antiretroviral therapy and societal-level interventions are needed in resource-poor countries.[1] Adequate resources also need to be made available to address depression and anxiety disorders in these regions.

Dan J Stein, Oye Gureje
Department of Pyschiatry, University of Stellenbosch, Cape Town 7505, South Africa (DJS); and Department of Pyschiatry, University of Ibadan, Ibadan, Nigeria (OG)
djs2@sun.ac.za

DJS is supported by the Medical Research Council of South Africa. The MRC Unit on Anxiety Disorders has received funding from drug companies in South Africa. DJS and OG have also received research grants and speaker's honoraria from several drug companies.

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