Understandings of depression: an interview study of Yoruba, Bangladeshi and White British people

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**Background.** Depression remains a major public health problem, but little is known about the views and understandings of depression held by many ethnic groups.

**Aim.** To explore views and understandings of depression in three ethnic groups—Yoruba, Sylheti-speaking Bangladeshi and White British—living in South London.

**Design.** Qualitative, semi-structured interviews, using vignettes describing depressed individuals.

**Setting.** General practice and the community in Southwark, South London, UK.

**Participants.** 20 Yoruba, 20 Bangladeshi and 20 White British people, recruited from primary care.

**Methods.** Interviews (in English for Yoruba and White British, in Sylheti for the Bangladeshi participants) were recorded and transcribed. Atlas ti software was used to organize the data.

**Results.** Views on the causes and cures for depression were diverse. A diagnosis of depression can have adverse social consequences in all groups. Magic had a role in both causation and cure in the Yoruba and to a lesser extent in the Bangladeshi groups. Religion was important for many people in all groups. Family factors were dominant in the Bangladeshi participants, whilst the White British often identified more ‘psychological’ causes of depression. Coping methods and health-seeking behaviours included religion, family, friends and neighbours, and becoming more active. Formal psychiatric interventions and taking antidepressants were not priorities.

**Conclusion.** Cultural models of depression, including its causes and treatment, are diverse, and are different among cultural groups. This study raises questions about the value of Western approaches to mild and moderate depression in these groups of patients.

**Keywords.** Depression, ethnicity, health beliefs, primary care.

**Introduction**

Depression is a global public health problem, contributing 12% of the total burden of non-fatal global illness. Patterns of treatment vary within the National Health Service (NHS), and rates of ascertainment and of adherence to therapy in general practice have long been causes for concern. The National Institute for Clinical Excellence (NICE) has recently published guidelines based on a review of current evidence. Guidance is particularly welcome in view of the concern expressed by the Committee on Safety of Medicines and the Medicines and Health Care Products Regulatory Agency (MHRA) about the prescription of selective serotonin reuptake inhibitors (SSRIs).

Additionally, the criteria for diagnosis of depression, including the DSM IV criteria, are constructs fashioned by the concepts of Western medicine. Even when a patient meets the DSM IV criteria for a major depressive episode, perceptions about aetiology, consequences and cure may differ amongst non-Western ethnic groups from those of people trained in the Western medical tradition. Moreover, patients who do not share Western perceptions of mental illness may be reluctant to engage with Western mental health services. A recent study of Black Caribbean, South Asian and White British older adults, conducted...
in London, found that a social model of depression is closer to the beliefs of older people than the traditional medical model, and emphasized the importance of making culturally appropriate inquiries about recent life events. A similar study in New York, in which vignettes of illness were used to depict depressive symptoms, showed how South Asian immigrants hold different beliefs compared with European Americans and identified the material presented in the vignette largely in social and moral terms. European Americans embraced a much more ‘biological’ model of depression.

Many cities in Europe are now multiethnic, and while it is important to try to diagnose and treat depression in a culturally aware way, little evidence is currently available on how to manage different ethnic groups. One approach to understanding different perceptions of depression is to interview patients in order to discover their ideas about causality, control, consequences, coping and cure. Qualitative research methodology and analysis can provide unique insights into beliefs and behaviours, as well as generate hypotheses that can lead on to larger-scale quantitative studies to determine which interventions are most likely to be effective either across all ethnic groups or for particular ethnic groups.

The aim of this study, conducted in three distinct ethnic groups, was to increase our understanding of the diversities, as well as the similarities, in views of depression held by people living in Southwark, South London, where 7.5% of school children speak Yoruba or a Benuic language and 2.5% speak Bengali and Sylheti.

Methods

The study was conducted from 2002 to 2004 in Southwark, South London, and involved patients registered with an inner-city general practice. The practice area contains a diverse cultural and ethnic mix of patients, with high concentrations of Nigerian, Bangladeshi and White British people. We advertised for volunteers from these ethnic groups to take part in the study by displaying and giving out leaflets in the surgery. The Bangladeshi Health Worker (AHK) asked people if they were willing to volunteer, because about 60% of the Bangladeshi people in the practice were unable to read either Bengali or English. The leaflets explained that we were doing research into how people from different parts of the world deal with emotional distress, and that we would like to hear their views. A White British GP (HL) interviewed the Yoruba and White British people, and AHK, who is from Sylhet in Bangladesh, interviewed the Bangladeshi people.

We planned to interview 20 Yoruba, 20 Sylheti and 20 White British subjects, considering it likely that we would achieve saturation, that is, conduct further interviews in which no new themes or ideas emerged, after this number. Our participants were purposely sampled for variation in age, gender, length of time in the United Kingdom, and for educational achievements and included people who had and had not suffered from depression.

Each participant was told a story about a person who fulfilled the DSM IV criteria for a major depressive episode. Six different vignettes were used in order to match the gender, age and family structure of each participant (see Fig. 1 for examples).

We used a semi-structured interview schedule, developed from discussions with patients and professional colleagues, and subsequently modified to include the important dimension of causality, to find out what the participants’ views were about the person in the story (see Appendix 1). Participants were given a 10-cm visual analogue scale with ‘ill’ at one end and ‘not ill’ at the other, and asked to mark somewhere along the scale how ill they thought the person was. We also asked participants about their own experiences of depression, which included what they thought had caused their depression, and what had helped them to get better.

The interviews, which lasted from between 30 and 90 minutes, were audio-taped and transcribed. The Yoruba people were interviewed in English, which is the official national language of Nigeria; AHK interviewed the Bangladeshi people in Sylheti, which has no written version, and these tapes were transcribed directly into English.

The transcribed interviews were imported into Atlas ti, a software programme used in the analysis of qualitative data. Components of the narrative—words, phrases and sentences—were given codes, partly related to the schedule used to begin the interviews and also partly by the use of grounded theory, when unexpected issues emerged from the interviews. The coding frame was developed iteratively, and resulted in the identification of 132 codes, which were subsequently collapsed to form coherent themes. After about 15 interviews in each group, no new codes emerged. Three broad themes were identified from this analysis, dealing with ideas about the causes of depression, attitudes to depression and means of coping with and treating depression. We also report on the specific issue of whether depression was considered an ‘illness’. Direct quotations from interview transcripts are included to highlight particular aspects of these themes, and the origins of these quotations are signified as Y (Yoruba), B (Bangladeshi) and W (White British).

Results

The 60 participants ranged from 18 to 80 years of age, with educational achievements varying from having
never been to school to completion of postgraduate degrees (fuller details are given in Tables 1, 2 and 3: available online at www.fampra.oxfordjournals.org). There were approximately equal numbers of men and women in each group. All the Bangladeshi people were Muslim. The Yoruba were mostly Christian, but some of their Christian churches also merged into traditional religious practices, with soothsayers as part of the church community. About half of the White British group was Christian. Fourteen Yoruba and fourteen White British, but only four of the Bangladeshi people, said that they had been depressed like the person in the story. The people who had been depressed gave longer interviews; most were keen to describe their experiences of depression and how they coped.

Causes of depression

Nearly all the participants wanted to discuss what might have caused the depression of the person in the story, and they gave examples of causes from their own life experiences (Y3) (Box 1). Ideas about the most likely causes of depression varied substantially between the three groups of interviewees. Curses, black magic, evil spirits and the devil were mentioned frequently amongst the Yoruba people, but less frequently amongst the Bangladeshi and not at all amongst the White British. Some Yoruba people explained that families could suffer mental illness because of misdeeds of their ancestors (Y7). An individual or a family in the United Kingdom may suffer from curses that travel from Nigeria (Y8). In the Bangladeshi group, where life is particularly focused on the family, family pressures could be intense. These pressures also involved trying to meet the financial demands of family in Bangladesh. For example, a man was threatened by a family member

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**Story 1: A woman**

She didn’t seem her usual happy self over the last few weeks, even though nothing bad had happened to her.

She had three young children: the boy aged 4 years, the girl aged 3 years and a baby boy aged 18 months.

She kept getting angry with her husband, and she cried a lot.

She kept waking in the night and was eating less.

She usually liked to go out shopping and to see her friends, but she had lost interest in all those things.

Instead she stayed at home, and kept walking about the house.

**Story 2: A man**

He didn’t seem his usual happy self over the last few weeks, even though nothing bad had happened to him.

He had a wife and three young children: the boy aged 4 years, the girl aged 3 years and a baby boy aged 18 months.

He kept getting angry with his wife and the children. He kept waking in the night and was eating less.

He usually liked to meet with his friends, and be with his family, but he had lost interest in all those things.

He had stopped going to work. Instead, he stayed in bed, or kept walking about the neighbourhood on his own for many hours.

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**Box 1  Origins of depression**

“She must be worried for something, or she’s got medical problem, or she’s being ignored, or she’s suspecting something between her husband and somebody else.” (Yoruba No. 3)

“If a family has got a madness, it means there is a curse on that family. They must have done something terrible in the past, maybe to somebody who is now coming back as a curse on them.” (Yoruba No. 7)

“There are different ways the devil operates, you know amongst Yorubas in Nigeria. So you don’t need to be there. You know, some people are here, and they may call them names at home in Nigeria, and they get crazy here” (Yoruba No. 8)

“Now his brother say like this on the phone: ‘You had better not come to Bangladesh or I will cut your stomach.’ Now how will his mind stay in place?” (Bangladeshi No. 20)
in Bangladesh when he was unable to meet these demands (B20). (Full details of the causes of depression are given in Table 4: available online at www.fampra.oxfordjournals.org.)

Amongst the White British and Yoruba people, although family problems were one of the most important causes of depression, break-up of friendships and partnerships and the ensuing isolation and anguish were also mentioned frequently (W13). Several Yoruba people said that they would have been protected from becoming depressed in Nigeria, because of the extended family living together in a compound, and also because of supportive neighbourhoods (Y6, 12).

Bangladeshi people also commented that there is less family support in Britain (B3).

Several people from both the Yoruba and White British groups mentioned that some individuals and families are more vulnerable to depression than other people. In spite of these few differences, it is remarkable how the groups shared so many perceived causes of depression (Table 4: available online at www.fampra.oxfordjournals.org) (Box 2).

**The stigma of a diagnosis of depression**

Most of the Yoruba people said they would feel ashamed by a diagnosis of depression (Y2, 3, 10). Amongst the Yoruba, marriage prospects could be threatened (Y5). One White British person discussed his own stigmatizing attitudes (W3) and one anticipated being stigmatized (W20) (Box 3).

All the Bangladeshi people said that they would accept the doctor’s diagnosis, but they gave no information about any stigma attached to the diagnosis.

**Coping with depression**

The ways of coping were plentiful and diverse and included psychological, social, medical and spiritual courses of action (Table 5: available online at www.fampra.oxfordjournals.org). In the Yoruba and Bangladeshi groups people believed that the root causes of depression should be addressed; otherwise the depression would return (Y10). However, in contrast with addressing the causes of depression, people also mentioned the importance of behavioural activation (engaging in purposeful pursuits) and distraction from the depression (W16, 5, 7, Y8) (Box 4).

Most people from all the ethnic groups used family and friends as their main support (W11). Obtaining help from a doctor was considered when the patient, family and friends had exhausted their means of coping, and also by the people who had no family and friends to rely upon (Y12). Some White British people talked about the importance of a confidential relationship with the doctor. In contrast, a Yoruba man questioned how a consultation with a doctor could be of use without involving the family (Y5).

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**Box 2 Socialization and depression**

“Feeling like that is a terrible lonely thing... Yeah, and it is hard, you know, and sometimes people don’t understand how you feel.” (White British No. 13)

“One brother lives away from other brothers and parents... all of them cannot live in the same house... You have to look after yourself.” (Bangladeshi No. 3)

“Back home... friends and family can still help you out. But here you have to do it yourself.” (Yoruba No. 12)

“You don’t even know that you have children at all because there are a lot of people who will look after them for you free of charge. Your mom is there, your aunts are ready... all the wives... My father has got several wives.” (Yoruba No. 6)

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**Box 3 Stigma**

“From the general community they would be against, sort of disgust, sort of ‘what’s wrong with you? Pick yourself up man... Sort of almost the same way you would look at a coward who had run away from the enemy guns.” (Yoruba No. 10)

“...if she had such a problem before her husband marry her, definitely she is not going to be married. Nobody will marry her.” (Yoruba No. 5)

“Sometimes we are happy with our gut attitudes. Sometimes we are not... I’d think of [depressed people] as a hindrance to the group dynamics, kind of thing...” (Yoruba No. 10)

“If I was organizing a trip out some place, they wouldn’t necessarily be in my thought, plans, because I don’t necessarily want to be around them.” (White British No. 3)

“It will be on my [medical] file that I have been depressed... bit of a sort of stigma with that.” (White British No. 20)

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**Box 4 Coping with depression: tackling the causes and engaging in activities and distraction**

**Tackling the causes**

“You know plantain? If you just cut it, you leave the root there, but give it some weeks, it is back again. So, to me, depression is like that... Yes you think you have destroyed it, but the root is still there that will send off the shoot again.” (Yoruba No. 10)

**Activities and distraction**

“I go out and walk along the river, because then you suddenly realize the world’s out there, and you get it into perspective. Never, ever, ever sit at home and think about what’s going on. Always do something else.” (White British No. 16)

“He should talk to people more. He should go out... you must go out, must talk to people, because if you don’t you’ll go crazy. You will go crazy. It sounds very much like me.” (White British No. 5)

“Go shopping. You often meet a lot of people just going shopping, neighbours et cetera, you know. Stop and have a chat and you feel more, um, in contact with real life... It’s a little bit of a break, and you feel part of the human race.” (White British No. 7)

“You know at times, when you are alone, you have time to think of so many bad things. But when people are around you... you laugh.” (Yoruba No. 8)
People from all groups were sceptical or ambivalent about antidepressants (W13, B4, Y7). However, other people saw a role for antidepressants (B19) (Box 5).

Amongst the Bangladeshi people, going to doctors in the United Kingdom was a substitute for lack of mullahs (Muslim priests) (B5). Religion played an important part in healing in all the groups. The church or mosque had a social as well as a spiritual role (Y3). If curses or witchcraft were believed to be causes, then religions were called upon. These religions could be Muslim, Christian or Traditional (B5, B2, Y3, Y17, Y7) (Box 6).

**Is the person ill?**

Opinion was divided in all ethnic groups as to whether the person in the story was ill or not; respondents indicated points all along the scale, indicating confusion and lack of consensus about whether depression constituted an illness (B3). Two Yoruba people marked in two places along the scale given to them. They both said that if they were in Nigeria, the person would be regarded as not ill, but in the United Kingdom, the person would be regarded as ill (Box 7).

**Box 5 Coping with depression: friends, doctors and drugs**

**Friends**

“...And that evening a friend rang and I told her, and she said ‘have you had anything to eat?’ And I realized I hadn’t had a thing to eat for about three days, not a thing. She said ‘you must have something to eat, you must do...’” (White British No. 11)

“If it is this country the only way [is]...to go to the doctor, but in Nigeria the people will tend to think of so many ways of helping out, according to individuals’ beliefs.” (Yoruba No. 12)

**Doctors involving the family**

“My own advice to doctors... if it is a woman, they should try to invite the husband... and tell him that look, the wife got a depression. So what’s going on? And they should, you know, try to advise them that he is the right person to help the woman out, because that woman is only with the doctor for a few minutes.” (Yoruba No. 5)

**Antidepressants**

“I think they are good, but not for a long period of time... because after a long time of it, your body is immune to them. I’ve took them... I think it’s only me that can make myself get better.” (White British No. 13)

“In this situation medicine will not benefit. This is mind matter, unrest of mind. So doctors’ medicine can not work.” (Bangladeshi No. 4)

“So I decided to take [the antidepressant] even though I don’t feel good in taking it. Actually, it doesn’t help me much. I think going to my church for counselling has helped me a lot.” (Yoruba No. 7)

“Taking medicine can change the mind... So medicine can make the brain normal and can make the heart normal... medicine can make him better.” (Bangladeshi No. 19)

**Box 6 Coping with depression: religion**

“If [you are] in Bangladesh there are mullahs... But in here [UK] not much mullahs, mainly doctors.” (Bangladeshi No. 5)

“I would go to mullah. Without mullah, doctor cannot do anything.” (Bangladeshi No. 2).

“I had people who supported me in the church, came to look after me and all that. And I had people who were really close to me, who were like my mom, like my sister. I was able to get out of it.” (Yoruba No. 3 talking about her postnatal depression)

“If you believe in the dark world, you go to the dark world again and they do some kind of voodooism, some kind of same... killing goats, killing sheeps, killing even human beings, some do it, child. Right, they remove the hands. They remove this, that...” (Yoruba No. 17)

“When they sacrificed the animal... to appease the spirits... You know they might ask her to take it to a river bank or to the bottom of a big tree... or to a very big junction like the roundabout at the Old Kent Road. If it is accepted by the spirit, all those things that is stopping her, go away instantly.” (Yoruba No. 7)

(Full details of coping methods are given in Table 5: available online at www.fampra.oxfordjournals.org)

**Box 7 Depression as an illness**

“If she is ill, there should be effect on her body, maybe stomach ache, or headache or some other effect on her body. Because there is no effect on her body, therefore with my little knowledge I think she is not ill. Perhaps she has a mental problem.” (Bangladeshi No. 3)

**Discussion**

Our findings from this study of three ethnic populations living in South London provide a timely reminder of the importance of cultural factors in the construction and management of depression in general practice. We have discovered a rich narrative of unpredictable beliefs and attitudes to depression. This unpredictability has major implications both for individual GPs dealing with patients with mood disorders and for those involved in planning mental health services in multi-cultural settings.

Several studies have identified disparate views on mental illness and mental health services. Bose et al. published two telling case histories of young Bangladeshi possessed by spirits, and Krause described the unique Punjabi concept of the ‘sinking heart’. Sulaiman et al. drew attention to the particular perceptions of depression held by Arab people in Dubai. Fairly recently, Marwaha and Livingston found that older white British and African-Caribbean people did not, generally, regard depression as an illness and regarded mental health services as more concerned with psychosis and violence than for people with depression. The studies of Asian and Caribbean patients conducted
recently in London and New York support our observation that non-White people often use a social or moral, as opposed to biological, explanatory framework for depression.

In our study, we have found further strong, culturally specific beliefs about the causes of depression and means of coping with it. Magic and spiritualism, as well as religion, dominated many subjects; ideas of causality, and the idea that spells and curses could cross both generations and continents, was particularly striking. These are unusual but important issues that need to be considered in obtaining a patients' history.

The role of family and friends, as both a cause of problems and a source of comfort, should be remembered. Sufficient information needs to be obtained from a patient to establish the social context. Strikingly, traditional Western medicine, such as seeing a GP or taking an antidepressant drug, ranked below other approaches to managing low mood and depression in most of our subjects, with social support, distraction and activity being favoured as first steps in coping. There is good evidence for both 'talk therapy' and behavioural activation in mild to moderate depression.

The strengths of the study include the large numbers of participants who were asked open-ended questions, which elicited a wide variety of responses, and the inclusion of native White British People, whose responses were sometimes unexpected. The study incorporated people with different degrees of acculturation to British society.

Limitations of the study relate partly to the fact that the interviewers had different backgrounds. The GP was more used to eliciting personal information and her interviews lasted longer. She is White British and so responses might have been tailored to please a White British woman GP. Conversely, the Bangladeshi Health Worker was part of the local community and responses may have been tailored for him and there may have been worries about revealing personal information such as history of depression to someone known in the community. He is also a man and the Bangladeshi women may have been wary of revealing information to him. Although we were unable to triangulate or back-translate these transcripts, the bilingual fluency of the Health Worker in Sylheti, his first language, and in English give us confidence in the accurate representation of what was said. We used only six different vignettes to match with participants' ages and life situations. If more vignettes had been used, so that each more closely matched the participant, there may have been even greater identification with the person in the vignette, which could have elicited richer responses. Although this study was conducted in a single general practice, we think that our findings are likely to be generalizable and to have wider applicability.

In his analysis of cross-cultural psychiatry, Helman enumerates five themes to which clinicians should pay attention—the extent to which cultural factors affect diagnostic categories; the role of culture in communication and understanding distress; the attitudes to depression held by members of the patients' own cultural group; the interpretation of symptoms and behaviour; and the role of social, political and economic pressures in causing distress. All five of these are clearly exemplified in the narratives provided in this study. Helman also warns of the dangers of over-emphasizing culture and missing the psychopathology.

Not only do our findings have implications for the design and delivery of services and for eliciting beliefs during the consultation, they also raise questions about the appropriateness of Western models of diagnosis and of management, and suggest a number of directions for the development of innovative approaches to treatment for different ethnic groups. These might include, for example, the provision of culturally specific information about understandings of depression to health care workers, as part of their training and continuing professional development, the familiarization of practice staff with idiosyncratic beliefs concerning depression in various ethnic groups and the provision of dedicated time for GPs to work with skilled translators in the exploration and management of distress in these patients.

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Contributors

HL had the original idea for the study, which she designed with RJ. HL and AK interviewed the patients. HL analysed the interview transcripts. HL and RJ drafted and completed the paper, on which AK commented. HL is guarantor for the study.

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References

Appendix 1 Interview Schedule

Revised 26 03 03

Initials Dob
Education
Home circumstances
Work

INTERVIEW

During the interview

• Greeting and thanks and how long have you been in England, and do you have any family nearby, and how is it in the UK for you?
• I have noticed that people from different countries sometimes cope with emotional distress in different ways. This interview is to learn about what you think about someone who is emotionally distressed, and how you think that person could cope.
• Go over information and consent.
• Explain the tape recorder and transcribing. Your name will not be mentioned.
• I am going to tell you a story, and then I want to hear what you think about the woman in the story. I’ll ask you all sorts of questions!
• Tell the story, and give the sheet to read. Repeat as often as needed.

1. What do you think is happening to this woman in the story? What, how, why do you think this?
2. What may have caused her to be like this?
3. Do you think people can become like this when nothing bad has happened to them?
4. How do you think she can explain what is going on to her friends? What do you think her friends might think of her?
5. What do you think her family might think?
6. Do you think that it is her fault?
7. What do you think this woman should do?
8. Have you ever experienced anything like this woman is going through?
9. If you were this woman, what would you do?
10. How did you/would you cope when/if you felt distress, and how you think that person could cope.
11. Did you/would you seek help from others? If so, from whom?
12. Do you think her family and friends may be able to help? If so, in what ways?
13. If you were this woman/man, how would you like your family to be involved? Would you...
14. What roles do magic, witchcraft, curses have in causes and treatment?
15. Do you think that this woman is ill? What does illness mean to you?
16. Measure illness on a visual analogue scale.
17. If a doctor told you that you were suffering from depression, what would you think?
18. What do you feel about taking medicines?
19. What are your views about taking medicine for an emotional problem?
20. Do you go out to work, or are you at home?
21. Do you follow any religion? Do you feel your religion would make a difference in this situation?
22. Is there anything else you would like to mention?