Depression: Facts, Myths and Stigma. Implications for mental health in Africa

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Introduction

The 22nd of March 2013 began like a regular school day. We were all gathered in our school's auditorium for our daily morning assembly. Usually, Benjamin, a close friend of mine who I had known since primary school, would lead us through the opening prayer.

However, on this gloomy day, my school's principal mounted the pulpit. I was bewildered because it was quite a rare occurrence. This urged me to listen attentively to words I didn't know would eventually break my heart. With tears in his eyes, he announced the demise of my friend Benjamin.

Benjamin committed suicide by hanging at his family home.

The effect of Benjamin's demise

Late Benjamin was a joyous and enigmatic man. He always found a way to light up any room he found himself in. He never showed any sign of depression, at least from the observations made by his immediate family and close friends. Nonetheless, I doubt if any of us truly knew the peculiarities of depression.

At school, the news of his demise caused a spontaneous barrage of false rumours about the nature of depression. Students, schoolteachers and even non-academic staff, all construed depression in their own terms. Some described depression as a spiritual attack of sadness. Others depicted it as a product of heart break from a failed relationship. This lack of understanding of what depression truly was might have made us miss key signs of depression late Benjamin manifested.

So, what truly is depression?

Depression: A mental disorder

With a rise in mental health awareness, depression has become a major topic of focus globally. It has no holistic definition, due to the fact that it shares a wide range of symptoms with normal conditions and other forms of mental illnesses.

Nevertheless, in 2012, the World Health Organisation (W.H.O) defined depression, as a common mental disorder that presents with depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration.[1] These are ubiquitous features anyone could experience or would have experienced at a point in their life. Thus, what really makes this definition diacritical, is it's opening statement; **"depression is a mental disorder."**

A mental disorder is a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation or behaviour that reflects a dysfunction in psychological, biological or developmental processes underlying mental functioning.[2] Hence, from this definition, depression is a syndrome caused by an abnormality in cognitive development and not just an innate emotional response to our daily challenges.

Nonetheless, in no way is it right to undermine our intermittent emotional responses or changes of mood, but to describe depression as just a "feeling" reflects true nescience. This is a regular phenomenon in Africa, especially in Nigeria where the average Nigerian dispels depression as a transient feeling that only the weak succumb to. It is a trend that needs to stop, as depression affects 7 million Nigerians and more than 264 million people globally. It respects no age group as it affects adolescents, adults and the aged. Among these age groups, the adolescents have the highest rates of major depressive episodes (14.4%) while the elderly have the lowest rate of major depressive episodes (4.5%).[3]

Thus, it is important to sensitize all age groups about the true meaning and peculiarities of depression because it is a global crisis.

Depression: Dissevering the facts from the myths

Over three centuries ago, depression had no real definition, cause or criteria of classification. Some doctors described it as a feeling of sadness or hopelessness. Some tagged it a side effect of aggression, lack of exercise or poor dietary habits. Some even went ahead to call it a product of the type of music genre one listens to. The lack of medical technology at the time caused a lot of misconceptions about depression.

Today, knowledge on depression has broadened, and thanks to medical advancement, the almost ambiguous thin line between the facts and myths of depression has thickened. Below are examples of myths and verified facts about depression;

1. ***Myth: Depression is an end product of chemical imbalances in the brain.***
   Fact: Depression is a product of a wide interplay of developmental and environmental factors.

In earlier times, the ethology of depression was often described as a consequence of chemical imbalances in the brain. Yes, chemicals are involved in the process of mood modulation but there are billions of chemical processes that interact to regulate our perceptions and mood. Nerve cell growth, connections and functions, all play a vital role in mood regulation and depression.

Through the help of Magnetic Resonance Spectroscopy, two important regions of the brain were discovered to be responsible for negative emotions and anhedonia that depressed patients manifest; these are the Amygdala and the Nucleus accumbens, respectively.

The Amygdala is a structure located deep within the brain, and together with the Hippocampus and Prefrontal cortex, our emotional responses such as pleasure, fear, anger and

sorrow, are regulated. However, in an individual suffering from depression, this interplay of structures is dysfunctional.

A Functional Magnetic Resonance Imaging (fMRI) study published in the *Journal of Neuroscience,* revealed that the Hippocampus of depressed women were 9%-13% smaller than that of non-depressed women. Further research showed that the continuous exposure to stress hormones impaired the growth of nerve cells in this region of the brain, leading to damage.[4] Now, damage to the Hippocampus reduces its input to the ventromedial prefrontal cortex (vmPFC). The vmPFC is a part of the mammalian brain that plays a role in the inhibition of emotional responses, decision making and self control.

This reduction of input to the vmPFC impairs the negative feedback mechanism between the vmPFC and the Amygdala, thereby making the Amygdala more active. This results in the persistent negative emotions that depressed individual's experience.

For the case of Anhedonia, the pathway involved in dopamine neurotransmission to the nucleus accumbens (reward centre of the brain) is dysfunctional in depressed individuals. Consequently, the otherwise normal motivation to seek reward is less active in depressed patients.

2. ***Myth: Depression isn't hereditary.***
   Fact: Depression is partly hereditary.

Genetic studies centered on families and twins provided solid evidence for the contribution of genetic factors to depression. For example, a meta-analysis on twin research data showed that the hereditary rate of depression is 37%. In addition to this, data from family studies showed a two to three fold increase in risk of depression in first degree offspring of patients with depression.[5]

Therefore, the fact that a family member suffers from depression doesn't mean that every other family member will. Rather, relatives of depressed individuals are more likely to suffer from depression than those of non-depressed individuals. Also, as earlier stated, other elements such as environmental factors are in play. Examples of these factors are stress and substance abuse.

3. ***Myth: You can simply snap out of it.***
   Fact: Depression can be managed through the use of medications and therapy.

Depression is a mental disorder that affects mood regulation. It isn't something one can easily snap out of. As with all other forms of health disorders or illnesses, it requires appropriate management.

Currently, depression is successfully managed through the use of drugs such as antidepressants, antipsychotics and anti-anxiolytics, in combination with therapies such as interpersonal psychotherapy, cognitive behaviour therapy, emotion-focused therapy and cognitive behavioural analysis system for psychotherapy. Under the guidance of health care providers(medical doctors, nurses and psychologists), these forms of treatments yield better positive outcomes than treatments of earlier times (drug use and isolation).

4. ***Myth: Depression only affects adults.***
   Fact: Depression affects both children and adults.

Another common misconception about depression is that it only affects adults. This is false, because depression, along with other forms of mental disorders like Attention Deficit Hyperactivity Disorder (ADHD) for example, affects children also. According to Centres for disease prevention and control (CDC), 3.2% of children aged 3-17 years (approximately 1.9 million), have been diagnosed with depression.[6]

This isn't surprising because depression is a form of mental illness and if illnesses can affect adults, then they can affect children also. Furthermore, it is imperative to remember that children have a vulnerable and immature state of mind and comprehension. Therefore, it is essential to never dismiss a child manifesting symptoms of depression.

5. ***Myth: Depression and sadness are the same.***
   Fact: Though sadness is a component of depression, it is quite distinct in depressed individuals.

Yes, depressed individuals experience sadness but theirs is distinct from that of non-depressed individuals. The basic difference lies in the duration and resolution of symptoms.

Depressed individuals usually experience long term sadness that lasts for months and even years. This is because of developmental dysfunctions in their brain's ability to regulate emotion and mood. The type of sadness non-depressed individuals experience usually resolves on its own or with the support of family and friends. That of depression, requires medication, psychotherapy and support from loved ones.

Also, it is imperative to note that sadness is just one if the symptoms of depression. Depression manifests as a wide range of emotional symptoms.

6. ***Myth: Depression only affects women.***
   Fact: Depression affects both sexes.

There's a world systemic belief that a weak man is one that expresses or shows any form of emotional vulnerability. Hence, the false assumption that depression only affects women originated from this belief.

A recent study done by W.H.O revealed that 29.3% of men and 41.9% of women, globally, suffer from depressive disorders. Of these population that suffers from depression, 1% of women and 7% of men commit suicide annually.[7]

From the statistics above, it can be inferred that men not only suffer from depression but are more likely to commit suicide than women. This, yet again, stems from the fact that cultural and social norms hinder men from discussing their feelings or reaching out for help. Hence, they are less likely to present with symptoms and have access to treatment.

Generally, some myths about depression aren't too far fetched from the facts. Nevertheless, as a way to abolish these extant myths, it is imperative for everyone to know the true facts about depression.

Depression and Stigma

It is impossible to talk about any anomaly of health without including the stigma that comes with it. People tend to ostracise anything that appears deformed or abnormal. Be it a human, animal, plant or non-living thing. Anything that appears distinct from normal, stirs up fear. As the popular saying goes, *"Men fear what they do not understand"*. Thus, the innate reaction of mankind is to segregate and shun. So, for depression, it's the same story.

Depression comes with a burden of stigma. Stigma from one's working environment, social life, school, family and self. However, it is important to note that there are distinctive types of stigma depressed individuals experience. Based on a research done by the American Psychology Association, depressed subjects experience three types of stigma; public, self and private stigma.

Public stigmas stem from the discriminatory attitude of the general public towards depressed subjects. In Nigeria for example, individuals with depression or any form of mental illnesses are usually ostracised in job selection processes or house leases. Even though they may suit the appropriate requirements or qualifications.

As opposed to public stigmas, self stigmas originate from internalised shame depressed individuals have about their own condition. They create a false sense of low self esteem, self worth and insecurity. Thus, reducing their interest in activities. This sets them on a long road of loneliness and further worsens their condition.

With institutional stigma, policies created by the government and private organisations, limit opportunities available for people living with depression or other mental illnesses. This may be deliberately done or not. It is a very common phenomenon in developing countries.

The mental health sector in these countries isn't given proper "attention" in terms of funding and maintenance. This is due to the fact that other areas such as primary health care, infrastructure, agriculture and education, are underdeveloped. Thus, a major quarter of their resources is allocated to these areas and
this hinders the availability of conventional treatment for the mentally ill.

With public shame, self guilt and shortage of opportunities, the depressed community seem to be placed in an ever shrinking box, that grows smaller till it becomes a single isolated entity. Therefore, there is a cardinal need to impugn the very fabric of stigma in our society.

Tackling the stigma associated with depression

In 1992, the World Federation for Mental Health (WFMH) designated October 10th as World Mental Health Day. On this day every year, over 150 member countries raise awareness and advocate against the social stigma associated with mental illnesses.

In 2012, the topic of focus was depression, with the theme *Depression: A global crises*. One of the main objectives of this initiative was to promote stigma abatement, with the aim of reintegration of the depressed community into the general populace. Highlighted recommendations and policy agendas which were advocated to be launched in several countries include;

1. ***Education of the general public:***

Prioritisation of public education through the use of on-foot awareness campaigns and media outlets (newspapers, magazines and social media. Focused discussions should be done on topics like the definition of depression, facts about depression and the treatment opportunities available for depressed individuals. This will help in enhancing the public's understanding of depression.

2. ***Establish national policies and programs on mental health:***

The creation and amendment of national mental health policies and programs is essential for long term action against stigma. Policies based on health insurance schemes, house leasing, school and job requirements should be established for the betterment of the depressed community.

3. ***Link the mental health sector with other sectors:***

Sectors such as education, law, welfare and non-government organisations(NGOs) should be encouraged to be actively involved in the fight against stigma towards the depressed community. For example, the Africa Mental Health Foundation aims at conducting mental health research, dissemination of findings, developing innovative practices for mental health services in the context of prevailing socio-cultural and economic factors in Africa, capacity enhancement in mental health and mental health research and advocacy in mental health and the rights of persons with psychosocial disabilities to influence policy.[8]

4. ***Promote research on depression:***

Enhance research into the genetic, physiological and psychological features of depression in order to increase the understanding of depression and bolster the fight against stigma.

Implications of mental health in Africa

With over 50 million Africans suffering from distinct forms of mental illnesses, it will be logical to think that mental health is a prioritised topic in Africa but the opposite is the case. This is due to the fact that Africa is burdened with conflict, terrorism, infrastructural underdevelopment, corruption, recurrent disease outbreaks and slow technological advancement. Therefore, mental health issues are at the end of the list of priorities for policy makers in African countries.

With a lack of information systems in most countries, it has become increasingly difficult to know how deeply mental disorders affects the general African population. However, recent large scale research and analysis by numerous organisations revealed the interplay of mental disorders and several detrimental conditions in Africa.

For example, in most African countries, the most frequent presenting disorders are psychosis, dementia, epilepsy, depression and mental retardation. Reports showed that poverty, substance abuse, malnutrition, shortage of access to quality health care, natural disasters, frequent wars and conflicts, were the existing etiologies of these aforementioned mental disorders.

In light of this, the W.H.O collaborated with the World Psychiatric Association (W.P.A) on a number of projects, with the aim of promoting psychiatry and mental health care in Africa. Some objectives of this collaboration are to strengthen mental health policies, adopt and implement regional strategies to prompt mental health care and to reduce the use of psychoactive substances.[9]

The journey to accomplish these objectives hasn't been easy due to inadequate human and financial resources, shortage of trained personnel and lack of standard information systems.

Nonetheless, measures have been put in place to overcome these challenges. Measures such as the creation of networks for the distribution of vital mental health information to several African regions, to hold regional meetings with the minister of health of every member African country, to organise and support health personnel training programmes and to promote the creation of mental health associations.

With all these aforementioned measures put in place, there is hope for the progress of mental health in Africa.

Conclusion

Depression is a global crisis that affects every age group and social class and in response to its increasing incidence, the W.H.O initiated the mental health Gap Action Programme (mhGAP) with the aim of aiding countries by increasing healthcare services for people living with mental, neurological and substance abuse disorders.

Also, the W.H.O developed simple and concise psychological intervention manuals for depression, that can be used by both healthcare and lay workers. All these were done in alignment with the Sustainable Development Goal 3, which aims to ensure healthy lives and promote well being for all ages.

References

[1] *Marina Marcus, M. Taghi Yasamy, Mark van Ommeren, and Dan Chisholm, Shekhar Saxena*
W.H.O Department of Mental Health and Substance Abuse, "Depression: A global health concern", 2012.

[2] American Psychiatric Association," Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (*DSM-5)",2013.*

[3]*Single care team, "Depression statistics 2021", January 21st 2021, https://www.singlecare.com/blog/news/depression-statistics/*

[4]*Harvard health, "What causes depression?", June 24 2019, https://www.health.harvard.edu/mind-and-mood/what-causes-depression/*

[5]*Georgia Liapko, "Is depression genetic?", Vista Pines Health, 2021. https://delphihealthgroup.com/*

[6] *Bitsko RH, Holbrook JR, Ghandour RM, Blumberg SJ, Visser SN, Perou R, Walkup J. "Epidemiology and impact of healthcare provider diagnosed anxiety and depression among US children." Journal of Developmental and Behavioral Pediatrics. April 24, 2018.*

[7]*World Health Organisation," Mental health and substance abuse", 2021. https://www.who.int/teams/mental-health-and-substance-use/gender-and-women-s-mental-health/*

[8]*World Federation for Mental Health, "Depression: A global crisis", October 10 2012.*

[9]*Ahmed Okasha, "Mental health in Africa: The role of W.P.A", 2002.*