Lost in translation

The language and experience of depression varies considerably from different cultural perspectives. **Divine Charura** explores some transcultural challenges, perspectives and themes when working with depression in private practice

Having spent many years working within different settings I have sat with countless clients experiencing mental dis-ease and psychological distress labelled as depression. Some of these have been medically diagnosed and consequently referred to psychological therapy services. Some, particularly those presenting in private practice, may not have been seen in a clinical or hospital setting and may not have a diagnosis or label but may still describe experiences of dis-ease.

The private practice setting presents different opportunities as well as challenges. Challenges for the therapist include working outside the frame of a multidisciplinary team, which may result in impasse that emerges from the process and dynamic of working with client content. This too, however, may be quite freeing, as working with a client as a sole practitioner also enables possibilities for the co-creation of a therapeutic relationship. There are benefits and challenges for the client too. The opportunity to work with the same practitioner over a period of time and to explore and process experiences is an important one. However, there may be challenges around whether the client feels understood, accepted, and safe enough to process his or her experience of depression in therapy. Furthermore, given the range of clients and the diverse cultural values they identify with, working with depression in private practice is not a simple, straightforward process.

Depression and its clinical categories

What is depression and how is it effectively treated? The National Institute for Health and Care Excellence (NICE) specifies that a diagnosis of depression can be made based on the existence of a range of symptoms that have been present for at least two weeks and at particular levels of severity.[1] These symptoms include low mood, loss of interest and pleasure, loss of energy, etc.

Due to space limitations I have adapted and summarised them as follows:

- Sub-threshold depressive symptoms – fewer than five symptoms of depression
- Mild depression – symptoms in excess of five that result in minor functional impairment
- Moderate depression – symptoms or functional impairment are between 'mild' and 'severe'
- Severe depression – most depression symptoms evident and the symptoms markedly interfere with functioning.

Although these four categories of depression are noted, it is suggested that assessment of depression should not rely on a symptom count alone. A comprehensive assessment should take into account how the symptoms affect an individual's ability to function. Having noted these categories, which are drawn from medically identified symptoms and diagnosis, it is important to apply theory to explore the possible psychological explanations for depression. This may offer the practitioner in private practice a different perspective from which to understand the client's experience.

Attachment

There is a plethora of theoretical explorations on depression within the psychology literature. These include psychobiological, genetic and neurochemical explanations for depression. However, one of the most frequently cited theories is Bowlby's attachment theory,[2] further explored by Ainsworth in the 'strange situation' study in Uganda conducted in 1978 as an empirical framework to assess infant responses to stressful situations.[3] In the study Ainsworth noted that, following separation from their mothers, infants display three distinct patterns of behaviour on return. Some seek to reconnect with their mothers, indicating minimal tendencies to avoid contact – Ainsworth describes these children as 'securely attached'. Others, whom Ainsworth describes as having an 'insecure-avoidant' attachment, avoid their mothers. Lastly, some children alternate between resistance and contact-seeking behaviours, which Ainworth describes as 'insecure-ambivalent attachment'.[3]

I have included this study in my introduction to transcultural perspectives as, following its completion in Uganda, Ainsworth conducted a second similar study of American babies. This study replicated similar findings about patterns of attachment observed in Uganda, highlighting the applicability of the attachment relationship to these two culturally diverse groups.[3] However, some of the attachment behaviours noted in the children differed. The American children hugged and kissed and the African children clapped when their primary care giver returned, highlighting the cultural conditioning of behaviours.[3] Later in this article I will highlight some points regarding the impact of culture on psychological presentation.

Following these studies, the influence of attachment throughout life has been widely accepted and critiqued. Some authors have postulated its association with depression in adulthood, and insecure adult attachment has been widely associated with affective distress such as depression.[4,5] Others, however, have argued that depression is mostly associated with an anxious ambivalent attachment style, as well as a preoccupation with, and fearful avoidance of, attachment relationships.[6] Different theorists concur that secure attachment is important and influential in supporting individuals through psychological distress, particularly where clients face major life stressors which may otherwise result in depression.[7]

Exploration of clients' experience of depression could be related to their attachment style. Such explorations, where the therapeutic relationship and process allows, should be tentatively done. Clients with an anxious ambivalent attachment, for example, may experience depression and distress at the possibility or experience of relationships breaking down. Their way of being and attaching may also be played out in the counselling room, and such clients may find it difficult to make a commitment to the therapeutic relationship. However, it is important to note that attachment should only be seen as a lens to look through during exploration of a client's experience and the endeavour to understand his or her process. Furthermore, life experience, difference, and transcultural influences impact on individuals in ways that challenge a simplistic understanding of attachment theory as a possible factor in depression. The following exploration of transcultural perspectives and challenges will highlight some components of practice that may be helpful to the practitioner.

Transcultural perspectives and challenges

To explain what is meant by transcultural, I draw on an inclusive definition in which 'culture' extends to race, gender, class, sexual orientation, disability, religion and age.[8] The inclusive nature of this definition encourages an approach to work with clients that values difference and individuality. It also highlights the different spheres from which depression can emerge, compounded by other existential experiences and processes. Clemmont Vontress, a prolific writer within the field of cross-cultural counselling, highlights the impact of transcultural perspectives on psychological wellbeing.[8] He supports the classical existential idea that the physical, interpersonal, private and spiritual realms of humanity are interconnected and that each needs to be attended to. If attention is not paid to these areas the person will fall out of balance, resulting in physical or psychological ill health.[8]

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Given this existential perspective, the challenge for therapists and clients alike is to explore where the depression experience may be emerging from. Another challenge is how the therapeutic encounter will help if the client's depression is a reaction to life stressors, trauma or loss. If the depression is not reactive, the challenge is to explore with the client interventions that are helpful. In all circumstances the therapist and client find language in order to co-create meaning.

The experience of depression through language

As language is one of the therapist's main tools, language formulation is central to transcultural thought. The client experiencing depression may have difficulty finding words and formulating language to share his or her subjective experience. On the other hand the therapist's endeavour to respond with empathic reflections are attempts within the therapeutic relationship to ensure that the client perceives to a degree the therapist's understanding of his or her experience.

As a result of transcultural differences between therapist and client, the therapist is challenged by the fact that what the client attempts to symbolise through language can be interpreted into multiple meanings. This can result in the potential loss of understanding of the client's subjective experience and felt meaning.[9] The client's inter-subjective reality is therefore at risk of getting lost in translation because in the process of communication there is a gap between the experience of self and the vocalisation of language.[10]

The language and experience of depression varies considerably from different cultural perspectives. In some cultures, for instance, depression is not accepted as a clinical diagnosis, and may instead be linked to other cultural beliefs. For example, in some belief systems it may be seen as a spiritual process and a time to separate oneself from the community in order to seek the deeper meaning of life or to connect with spiritual realms. Within some African cultures, severe depression that manifests with suicidal tendencies may be viewed culturally as emerging from witchcraft.

This would present a major challenge for the therapist because the client's belief system may draw from other views of what would be helpful.[11] Furthermore, in connection to language, direct equivalents for some words do not always exist in other languages. For example, in the Zimbabwean Shona language there are no direct translations for the words 'depression' or 'anxiety'. The closest interpretation would be 'thinking too much'. Examples from other cultures include terms such as 'shenjing shuairuo' in China, which translates to weakness or exhaustion of the nerves or nervous system. This is synonymous with the symptoms of lethargy in depression or more closely linked to what we term a nervous breakdown in the West.[12]

The important point for therapists in private practice is to be aware that different clients may have their own cultural understanding of diagnosis and language to describe their experience, which may be in contrast to the scientific Western diagnosis of depression. Furthermore, the therapist has to be tentative and aware of the client's perception of therapy, and understand the client's somatic language rather than the literal translation of what they say.[11] It is important therefore for therapists to develop transcultural linguistic sensitivity and competency. This does not involve therapists being fluent in speaking the client's language but rather being sensitive to the language they use in their work with clients. It is also important to be sensitive and competent when exploring meaning and responding empathically when working with a wide range of culturally different clients.[13]

The importance of the therapeutic relationship

Rogers' core conditions for therapeutic growth and change inform the therapeutic relationship on which most modalities accept a successful relationship is built.[15] Empathy, congruence, and unconditional positive regard for the client should therefore be at the centre of our practice and presence and the therapeutic encounter. From a transcultural perspective, the following skills will enable therapists in private practice to enhance the therapeutic alliance and work more effectively with depression:

- knowledge of depression categories and how these fit with clients' experience
- openness to co-explore the client's experience through a theoretical lens like attachment theory
- sensitivity to the client's subjective experience and formulation of language when understanding his or her felt sense of depression, remembering the seven categories that define culture given earlier: race, gender, class, sexual orientation, disability, religion and age
- a commitment to continually developing transcultural linguistic sensitivity and competencies
- an ability to convey therapeutic, facilitative conditions in a culturally consistent and meaningful way.

Working in private practice with clients experiencing depression is never easy. However, engagement in perspectives that offer transcultural awareness and dialogue provides a platform from which skills can be drawn to enhance our competence with this client group. ■

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