Depression in Indigenous Australians: getting it right

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Refining our diagnostic concepts and understanding their phenomenological basis will allow culturally meaningful, person-focused care

The Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders note the lack of comprehensive epidemiology data for Indigenous Australians, citing the paucity of culturally appropriate research and other methodological problems.[1] In a recent review, the cited prevalence rates of major depressive disorder among Indigenous Australians ranged between 4.3% and 51%.[2] The authors argued for more research, identifying a lack of instruments validated in Indigenous populations; they also expressed concern that it may not be appropriate to apply Western nosology to non-Western populations, and that over-, under-, and misdiagnosis may lead to inaccurate prevalence estimates.[2] A number of instruments for assessing social and emotional wellbeing in Australian Indigenous people have been developed, attempting to correlate Western diagnoses of mental disorders with Indigenous Australian concepts of health.[3]

In this issue of the Journal, the Getting it Right Collaborative Group report using the 9-item Patient Health Questionnaire (PHQ-9), with phrasing culturally adapted for five Australian Aboriginal language groups, to screen for depression in Indigenous people in a variety of settings across Australia.[4] Their adapted PHQ-9 (aPHQ-9) was found to be acceptable by the Indigenous participants, and had criterion validity when compared with the Mini International Neuropsychiatric Interview (MINI), designed for detecting psychiatric conditions defined by International Classification of Disease (ICD) and Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria. A 22% point prevalence of major depressive episode in the authors' study population suggests a high rate among Indigenous people, in accord with studies that have found that the prevalence of psychological distress[5] and depression[6] was up to three times as high for Indigenous Australians as for non-Indigenous Australians.

Depression as a specific psychopathological syndrome is complex and multifaceted, and is probably oversimplified by the checklist approach to diagnosis that is inherent to classificatory systems such as the DSM and ICD. These checklists are useful simplifying devices for dealing with complex mental phenomena, obscuring variation and providing a framework for understanding the

"natural world".[7] To what extent, however, does the presentation of depression by Aboriginal and Torres Strait Islander Australians, given their history of cultural destruction, marginalisation and colonisation-related trauma, differ from that of other Australians? A recent article highlighted differences in cultural traumas in different Australian Indigenous populations and their influence on the prevalence of psychosis.[8] How does a clinician distinguish the psychological effects of ongoing cultural trauma, racism, poverty, disempowerment and social exclusion — which no doubt increase the likelihood of depression — from a clinical diagnosis of depression?

The Ways Forward report of 1995 urged culturally respectful and Indigenous people-led approaches to addressing problems conceptualised as mental health disorders.[9] The aPHQ-9 may have good cultural applicability, but it does not necessarily measure the specific and perhaps unique aspects of depression in Indigenous Australians: it cannot determine whether depression as a clinical and pathological syndrome is the same across Western and Indigenous Australian settings. Diagnosis involves more than translating the PHQ-9 into Indigenous words; for example, the concepts being translated should have equivalence and importance in Indigenous cultures (item equivalence).[3]

Interestingly, the Getting it Right investigators identified seven key features of depression in Indigenous men that were not covered by the PHQ-9: anger, weakened spirit, homesickness, irritability, excessive worry, rumination, and drug and alcohol use.[4] This is an important aspect of their article, and resonates with clinical experience; it suggests the need to re-conceptualise the depression diagnosis, moving beyond the traditional core features of depressed mood or anhedonia as defined for Western populations. Additionally, the authors emphasise the need for culturally appropriate interview methods, including structured staff training and involvement of local cultural consultants. This is an important practice point for all clinicians: reliability of diagnosis requires cultural sensitivity and security, and all health services need competence in this respect.[10]

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• doi: 10.5694/mja2.50230 • See Research (The Getting it Right Collaborative Group).

Greater phenomenological understanding of depression in a cross-cultural context is a necessary aspirational goal. The current classifications and criteria, whether based on ICD, DSM or another classificatory system, are not set in stone, but are works in progress. Diagnostic categories are constructs that provide an organising framework for clinical experience and treatment decisions; and while reliability of diagnosis is improved by studies such as that reported by the Getting it Right Collaborative Group, we should continue to refine the utility of our diagnostic concepts and clarify the phenomenological underpinnings of these constructs.[11] This will lead us to culturally meaningful, effective and person-focused care. The article by the Getting it Right investigators highlights the fact that the culturally sensitive aPHQ-9 is an advance, but not the endpoint in our understanding of depression in Indigenous Australians.

Competing interests: No relevant disclosures.

Provenance: Commissioned; externally peer reviewed. ■

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