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Depression after traumatic brain injury: A biopsychosocial cultural perspective

Durga Roy [a,*], Geetha Jayaram [a], Alex Vassila [a], Shari Keach [b], Vani Rao [a]

[a] Department of Psychiatry and Behavioral Sciences, Johns Hopkins University School of Medicine, Baltimore, MD USA
[b] Johns Hopkins Bayview Medical Center, USA

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ABSTRACT

There are several challenges in diagnosing and treating mental illness amongst South Asians. Often times, formulating a patient's case presentation cannot adequately be accomplished strictly using a biopsychosocial model. The cultural components play an imperative role in explaining certain psychiatric symptoms and can guide treatment. With the growing population of immigrants coming to the United States, many of which require treatment for mental illness, it is essential that clinicians be cognizant in incorporating cultural perspectives when treating such patients.

The authors describe the case of a 24-year old South Asian male who suffered an exacerbation of a depressive syndrome after a traumatic brain injury. Using a biopsychosocial cultural approach, this case highlights how South Asian cultural values can contribute to and incite psychiatric symptoms while simultaneously providing protective drivers for treatment outcomes.

1. Introduction

Mental illness amongst South Asians in the United States (US) can be challenging to assess and treat due to several factors: the negative social attitudes towards mental illness, somatically focused symptom presentation, lack of empathy and understanding of mental illness among family members or care providers, and avoidance of mental health services by patients and family. Because of the negative stigma that is associated with mental illness, South Asians are less likely to disclose their emotional symptoms and thus have difficulty receiving treatment. Additionally, family members may underestimate the nature and/or severity of illness in their loved ones and discourage psychiatric treatment as a result. Non-South Asian clinicians may find it challenging to distinguish such cultural factors from biopsychosocial factors.

In general it is important for clinicians to be aware how culture contributes to mental illness itself. Culture can be defined as attitudes, values and beliefs and behaviors shared by a people but also includes culture related experiences related to being an ethnic minority (Hwang et al., 2008). As outlined in a paper by Hwang et al. (2008), culture affects the "prevalence of mental illness, issues with diagnosis and assessment, etiology and course of disease, phenomenology and how distress can be expressed, certain coping styles and help seeking behaviors, as well as issues with treatment interventions" (Hwang et al., 2008).

South Asian values can be considered allocentric, or group-oriented (Tavkar et al., 2008). Imbibed within this culture are beliefs that sacrifices should be made by individuals for the better good of the family (Tavkar et al., 2008; Segal, 1998). There can be considered a sense of collectivism within the South Asian cultural system in which there is a practice of giving priority to the group as a whole rather than to the individual. Often there are expectations of younger generations to excel in education and develop lucrative careers. If these expectations are not met, a sense of shame upon the family may develop. In a study conducted by Bhattacharya and Schoppelrey (2004), two entities in the Asian culture that steered parental expectations were the responsibility of children in enhancing family pride as well as education which would enable advancement through the social class and the caste systems (Bhattacharya and Schoppelrey, 2004).

This may predispose South Asians to certain risk factors in the development of psychopathology. Often younger South Asians,

* Corresponding author. Tel.: +1 410 550 9616; fax: +1 410 550 8191.
E-mail address: droy4@jhmi.edu (D. Roy).

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particularly students, are placed under immense pressure to excel academically, and often develop mood disorders leading to suicidal thoughts and behaviors. When parental expectations are not met, one feels guilty and ashamed. The individual's family often compounds the individual's shame with their own sense of shame and anger. The failure of an individual subsequently represents a failure of the entire family. This can lead to cognitive representations which predispose to depressive symptoms (Wong et al., 2014). Parents may also exert control over their children which impacts the nature of both maternal and paternal bonding. A study conducted by Singh et al. (2012) revealed that Indian college students who experienced affectionless parental control and neglect had higher rates of hopelessness and suicidal ideation (Singh et al., 2012).

Asian Indians may often explain psychological distress as a violation of some moral or religious principle or spirit possessions. Physical and mental deficits are thought to be God's will or past karma. These factors may add to the delay in seeking professional help (Tavkar et al., 2008; Conrad and Pacquiao, 2005). While the above factors may influence the development of certain psychiatric disorders, one could argue that this collectivism and belief in moral and religious principles might also protect the South Asian patient from the sequelae of severe mental illness, namely suicide.

All of the above points should be considered when discussing potential precipitants for symptom presentation within South Asians with mental illness. This warrants an accurate and comprehensive approach to psychiatric diagnoses and ultimately treatment.

A biopsychosocial perspective may often be inadequate in accounting for all aspects of a patient's illness. Cultural contributions are essential in comprehensively understanding such patients and can provide for more rigorous treatment approaches. The biopsychosocial model has been described as a scientific model created to include aspects absent in the biomedical model (Engel, 1980). As Engel describes in his paper, the biopsychosocially oriented physician should pay attention to not only biological factors but also psychosocial factors that are both protective and increase the risk for destabilizing a person's emotional homeostasis (Engel, 1980).

Excluding the cultural components from this model however, can leave out vital components of a patient's psychiatric presentation, particularly when it comes to both diagnosis and treatment. Proponents of the cultural formulation model, as described by Lewis-Fernandez and Diaz (2002) stress the importance of assessing cultural values as they can play a significant role in an individual's psychiatric symptomatology and can highlight help seeking preferences. These proponents also argue that this can be even more important when physicians and patients are from different cultural backgrounds as an understanding of patients' cultural values can guide treatment (Lewis-Fernandez and Diaz, 2002; Mezzich et al., 2009).

The authors of this article report the case of a young South Asian male living in the US who developed exacerbation of a major depression after a traumatic brain injury. His story illustrates aspects of cultural and social conflicts that need examination in order to comprehensively understand his symptomatology. His presentation reflects on how cultural factors can be both a hindrance in mental health treatment yet simultaneously protective to adverse events that would otherwise arise from severe mental illness. An example of this is suicide. As the numbers of immigrant populations requiring mental health services continue to rise, it is imperative for clinicians to incorporate a cultural mindset when formulating, diagnosing and treating these patients.

2. Case presentation

2.1. Chief complaint

Mr. P is a 24-year old Indian male with history of severe traumatic brain injury who was presented to the Johns Hopkins Neuropsychiatry clinic for evaluation and management of mood, cognitive and behavioral symptoms.

2.2. Present illness

Mr. P was reportedly doing well until he sustained a severe traumatic brain injury (TBI) in 2008. A few months after the injury he developed a myriad of depressive symptoms including persistent low mood, anhedonia, decreased self-attitude, feelings of frustration, hopelessness and passively suicidal thoughts. He also reported cognitive symptoms including difficulty learning new information, processing information, distraction and an inability to stay on task.

Prior to the TBI, he had one episode of depression during his second year of college and was treated with fluoxetine 20 mg with good response. After the TBI, his episodes of depression were reportedly longer and more intense, lasting several weeks in comparison to his first episode. He was frustrated with his living situation and lack of independence. He repeatedly spoke about the "high expectations and demands from Indian parents," including his parent's refusal to let him live independently in the college dormitory in order to integrate with Western college peers. His parents encouraged him to associate with predominantly Indian peers and maintain a similar network even outside school. As a result, he reported strong feelings of inadequacy and failure for not accomplishing as much as his Indian peer counterparts.

Months prior to coming to the Johns Hopkins Neuropsychiatry clinic he had sought psychiatric treatment elsewhere. The dose of fluoxetine was increased from 20 mg to 30 mg and then to 40 mg with minimal improvement in his depressive symptoms. This previous psychiatrist had also started him on methylphenidate 5 mg and donepezil 10 mg, which had led to some improvement in his attention and short-term memory. At the time of initial evaluation, he denied any current or history of manic or psychotic symptoms.

2.3. Family, personal and social history

At the time of initial evaluation, his father was 54 years old and had diabetes. His mother was 49 years old and had Rheumatoid Arthritis. His 20-year old sister was in good health. Both parents were born in India and raised in the Hindu religion.

His father is trained as an ear, nose and throat (ENT) surgeon in India. Since coming to the US he had changed his career. He was at first involved in a business with a friend in North Carolina but later gave it up, moved to Baltimore and joined the Physician's Assistant program. He was still training at the time Mr. P first came to the Johns Hopkins Neuropsychiatry clinic. Mr. P's father reportedly gave up a lucrative ENT practice in India and moved to the US to provide better academic opportunities for his children. As per Mr. P's report, his father was the head of the family and made all family decisions.

There was no known neuropsychiatric history in any of Mr. P's close or extended family members, except for a stroke in a paternal uncle. Mr. P had no history of current use of alcohol, tobacco or illicit drug use, and no significant legal history.

Mr. P was born and raised in India. He came to the US 11 years ago. He was in the 10th grade when he and his family arrived from India to North Carolina. He completed his high school and then