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A Cross-Cultural Perspective on Depression and A Comparison of Treatment Approaches

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ABSTRACT: Depression is recognised as one of the oldest known psychiatric disorders. It is known that in non-Western societies, this disorder is predominantly expressed through physical symptoms and that suicide rates are lower compared to Western societies. Conversely, it is stated that in Western societies, feelings of guilt more frequently accompany depression, and that this phenomenon is explained by the influences of the Judeo-Christian tradition. For example, the belief that the individual is inherently sinful features among these explanations. In many cultures, it is observed that the behaviour of seeking help is shaped through physical complaints. The application of Western psychiatric diagnostic and treatment methods without flexibility can lead to underlying psychosocial problems being overlooked in societies where physical expressions are predominant. For this reason, taking cultural sensitivity into account in the assessment of depression is regarded as a fundamental necessity.

KEYWORDS: Depression, Culture, Somatisation.

INTRODUCTION

An examination of the historical development of research on depression reveals that this field has a history stretching back to very ancient times. Galen, the physician and philosopher from Bergama who lived in the 2nd century AD, defined melancholia by associating it with states such as fear, a tendency to withdraw from people, an inability to derive satisfaction from life, and despondency. He also drew attention to the role of environmental factors and hereditary traits. Whilst before Galen's approach, melancholy was largely treated as a broad-spectrum mental disorder, its association with sadness and grief became more pronounced through his contributions. By the Middle Ages, Ibn Sina, one of the prominent figures of the Turkish Islamic world, also offered his assessments regarding the concept of melancholy. Ibn Sina treated this condition as a distinct emotional state and stated that the imbalanced distribution of bodily fluids led to the emergence of various depressive conditions. This approach is regarded today as a precursor to neurotransmitter-based explanations. In the 17th century, with the publication of Robert Burton's *The Anatomy of Melancholy*, melancholia was explained primarily through physical foundations and addressed within a framework closer to contemporary symptoms. In the early 20th century, Emil Kraepelin assessed melancholia as a symptom of depression and presented a framework that conceptually approached current definitions. According to Kraepelin, the fundamental characteristic of depression is a marked decline in mood accompanied by a slowing of mental and physical processes. However, in his approach, the onset period was considered to be post-menopausal in women and late adulthood in men. By the 21st century, thanks to technological advancements, findings regarding monoamines had increased as a result of the work of researchers such as McLennan, Brodie, Shor and Alec Coppen, and depression came to be increasingly grounded in biological foundations. Furthermore, the development of psychoanalytic, behavioural and cognitive approaches has also contributed to a more comprehensive understanding of this concept (Yetkin and Özgen, 2007).

Depression is classified as a mood disorder and is one of the most prevalent psychiatric conditions. Epidemiological data indicate that approximately 13 per cent of women and 8 per cent of men experience depression in any given year. According to the results of the Turkish Mental Health Profile Study, the prevalence of depressive episodes was determined to be 2.3 per cent among men, 5.4 per cent among women, and 4 per cent in the general population. These findings indicate that depression is observed approximately twice as frequently in women compared to men (Psychopharmacology Scientific Research Unit). In general terms, depression is defined as a condition characterised by a prolonged loss of self-confidence, an inability to derive pleasure from life, an increase in feelings of hopelessness, and a state of apathy. An individual's living conditions can influence the likelihood of

developing this condition. Some factors reduce the risk, whilst others increase it. Chronic medical conditions, low socio-economic status, living alone, divorce, unemployment, the loss of a loved one, childhood trauma, a work or family environment involving intense stress, and alcohol and substance use are among the primary factors that increase the likelihood of developing depression. Despite its prevalence, the difficulty in diagnosis increases the risk of the condition taking a chronic course. In advanced stages, serious conditions that may result in suicide can arise. The fifth edition of the Diagnostic and Statistical Manual of Mental Disorders defines various subtypes under the heading of depressive disorders. These include dysthymic disorder, major depressive disorder, persistent depressive disorder, premenstrual dysphoric disorder, substance- or medication-induced depressive disorder, depressive disorder due to another medical condition, and unspecified depressive disorder. The condition commonly referred to as 'depression' in everyday language is generally considered to fall within the scope of major depressive disorder. According to the DSM-5 criteria, a diagnosis of major depression requires the presence of loss of interest and pleasure, depressed mood, changes in sleep and appetite, psychomotor retardation, feelings of guilt, difficulty concentrating, loss of energy, and suicidal thoughts. However, the DSM does not make a hierarchical distinction between these symptoms. Whilst some symptoms may also be observed in ordinary states of sadness, others are assessed as more severe and clinically significant. For this reason, the severity of symptoms is considered a distinguishing factor. Indeed, in some sources, psychomotor retardation, suicidal ideation, psychotic symptoms, feelings of worthlessness and significant functional impairment are classified as more severe symptoms, whilst sadness, loss of appetite, sleep disturbances, inattention and fatigue are listed as milder symptoms (Wakefield et al., 2017). In this context, taking the severity of symptoms into account during the diagnostic process plays a significant role in distinguishing between normal sadness and depression.

Depression is often seen alongside various psychological and physiological conditions. Certain physical conditions, such as heart disease, stroke, diabetes and Parkinson's disease, can both co-occur with depression and contribute to its development. Furthermore, psychiatric conditions such as anxiety disorders, obsessive-compulsive disorder, schizophrenia, eating disorders, and alcohol and substance dependence may also occur concurrently with depression . This comorbidity is quite common, and often multiple conditions co-occur. In particular, it has been established that anxiety disorders co-occur in a significant proportion of patients with depression. Research indicates that depression is frequently observed not only in individuals diagnosed with depression but also in those with anxiety disorders. It has been found that approximately 75 per cent of patients diagnosed with depression in primary care also have an anxiety disorder (Türkçapar, 2004). Based on epidemiological data, it has been calculated that the likelihood of developing an anxiety disorder in individuals diagnosed with major depression increases by between 3.3 and 8.2 times, whilst the risk of individuals with an anxiety disorder experiencing depression within a year rises by between 7 and 62 times (Hirschfeld, 2001).

Consequently, this study will analyse the cross-cultural impact of depression.

The Concept of Culture

The endeavour to comprehend and make sense of the world, which emerged alongside human existence, has remained a fundamental issue throughout history. Over the course of history, as the human population grew, diverse communities emerged, and individuals continued their attempts to name and interpret the phenomena they observed in their surroundings. These communities, formed in parallel with population growth, have united around a shared consciousness to give rise to social structure (Aslan, 2018). Society is a structure formed by individuals living together and cooperating within the framework of a shared civilisation throughout historical development. Society possesses a unique reality and possesses distinctive qualities not found in other elements of the universe or present in the same form (Durkheim, 2010). In this context, every society has its own unique system of values in its processes of perceiving and interpreting the world. Societies ensure their continuity by transmitting this whole of values from one generation to the next through culture.

Due to the multi-layered and complex nature of the concept of culture, it has been defined in various ways by different disciplines and researchers. Definitions of culture continue to be formulated today. One of the most widely accepted definitions has been put forward by UNESCO. According to this, culture is a comprehensive structure comprising not only the material and spiritual elements that define a society or social group, but also their mental and emotional characteristics; it encompasses not only science and literature, but also lifestyles, fundamental human rights, value systems, traditions and beliefs (UNESCO, 1982). As well as being a structure that embodies the norms, values and beliefs of societies, culture also possesses universal characteristics that can be observed across different societies.

Universal Characteristics of Culture

"The following characteristics of culture are universally present in every society:

1. Socio-cultural forms are learned.
2. They are logically integrated. They are also functional and meaningful.
3. All socio-cultural systems are constantly changing. Culture has a dynamic structure.
4. They are transmitted through symbols. They are passed down from generation to generation as part of the social heritage.

5. Every culture possesses a value system.
6. They facilitate reasonable, effective and automatic interaction among members of society.
7. They are shared in distinct ways. Individuals participate in cultures through 'acculturation'.
8. It is a dominant factor in the emergence and formation of social identity.
9. It is a marker that distinguishes one society from others. " (Tezcan, 1991)

Every society has unique elements that define its cultural structure. These elements consist of spiritual components such as values, language, norms, beliefs and traditions, as well as material components such as housing and clothing. Culture, which is the sum of these elements, serves as a fundamental component ensuring the continuity of the social structure. Maintaining its continuity through intergenerational transmission, culture is regarded as a social heritage that plays a decisive role in the formation of individual identity.

Like other societies, Turkish society possesses its own distinctive cultural characteristics. Respect for elders, hospitality, generosity, courage, the value placed on women, the importance of child-rearing and honesty are among the prominent qualities of Turkish culture (Aslan, 2018). Furthermore, the concepts of family, mother and father, and the meanings attributed to these concepts are also examined within a cultural context. The family is regarded as the smallest unit of society. The meaning of the family, as a universal institution, varies between traditional and modern societies. This difference stems from the values and expectations that societies place upon the family (Bozkurt, 2005). The family is defined as a community comprising adult individuals bound by kinship ties who take responsibility for the care of children (Giddens, 2000). Furthermore, the family is an institution that ensures the continuity of the human race, forms the basis of social relations, and facilitates the transmission of material and spiritual values (Sayın, 1990). The structure of the Turkish family has been shaped over the course of history in accordance with specific traditions and values. Although changes have occurred over time, this structure continues to bear the traces of historical accumulation. In traditional Turkish culture, characteristics such as obedience and conformity to the father, who represents authority within the family, are prioritised. Whilst women also share these characteristics to a certain extent within this structure, the son is regarded as holding a more privileged position compared to the daughter (Çelik, 2010). The family structure, which took shape in the pre-Islamic period in line with a nomadic lifestyle, underwent changes with the transition to a settled life, and intra-family relationships took on a different dimension. The loyalty of women and children to figures of authority has been a characteristic that has persisted both in the pre-Islamic and post-Islamic periods (Doğan, 2001). However, whilst the final say in decision-making processes concerning children typically rests with the father, the significant influence of the mother in the formation of these decisions makes it difficult to explain the Turkish family structure solely through a patriarchal framework, and such a generalisation limits the characteristics of this structure (Geçtan, 2002; cited in Çelik, 2010). The concept of the family is understood within Turkish culture and religious life through the metaphor of the hearth. The preservation and transmission of traditions from one generation to the next is associated with the continuity of this hearth, and this continuity acquires a symbolic meaning through the continued existence of the family (Çelik, 2010). The traditional characteristics of the Turkish family structure date back to the late Ottoman period, and the reforms implemented after the establishment of the Republic have contributed to the evolution of this structure into a more modern form (Vergin, 1991; cited in Çelik, 2010). The process of modernisation is causing profound changes in traditional ways of life and leading to the emergence of elements such as individualism, institutionalisation and rationality in the relationship between the individual and society (Çelik, 2010). This process of change has its most pronounced effect on the family institution and brings about significant transformations in family structure. However, despite these transformations, it is not possible to claim that the social importance of the family has diminished (Kirman, 2005). The rapid changes occurring in traditional lifestyles bring with them issues of imbalance and may cause some families to resist modernisation. This situation occasionally manifests itself in Turkish family life by causing modernisation to take on an irregular and contradictory structure (Göle, 2008).

Culture in Turkish Society

In Turkish society, both traditional and modern family structures coexist, and the differences between these two structures can be summarised as follows.

1. In traditional societies, individuals' attitudes and behaviours are more group-oriented, with collective interests taking precedence. In modern societies, however, individual needs and expectations take priority.
2. Whilst solidarity and sharing within the extended family are paramount in traditional structures, the nuclear family structure and a competitive mindset are prevalent in modern societies.
3. Whilst kinship ties play a decisive role in traditional societies, in modern societies these bonds have weakened and remain largely on an emotional level.
4. In modern societies, economic gain and standards of living take centre stage, whereas in traditional structures these factors remain in the background.
5. In traditional societies, fertility and mortality rates are high, whereas in modern societies these rates are low.
6. In traditional structures, status is determined by age and position within the family, whereas in modern societies, individual achievement and effort take centre stage.

7. In traditional societies, marriages are arranged by family elders, whereas in modern societies, individuals' own choices are decisive.
8. In traditional societies, behaviour is shaped within the framework of specific norms, whereas in modern societies, a wider variety of behaviour is observed (Güleç, 1999).

Given these differences, many researchers suggest that the direct application of psychotherapy theories to traditional cultures may have limited validity (Güleç, 1999).

The Abandonment Depression Theory, developed by James F. Masterson, is classified within psychodynamic psychotherapy approaches. Whilst working in the adolescent ward of a hospital in the 1960s , Masterson observed adolescents admitted for reasons such as substance abuse, uncontrolled sexual behaviour, suicide attempts and running away from home. Despite views suggesting these behaviours represented a temporary adolescent crisis, his review of the literature failed to uncover sufficient evidence to support these claims. The fact that adolescents admitted to hospital began to exhibit depressive symptoms once their impulsive behaviours were brought under control led Masterson to deepen his research in this area. During this process, he was influenced by the work of Margaret Mahler and proposed that a developmental stagnation occurred during the re-approachment phase of the separation-individuation process. Furthermore, drawing on object relations theory, the neurobiological research of Allan Schore and his colleagues, and the work of Daniel Stern, he developed a model of a psychological structure shaped by mutual interaction (Özakkaş, 2018). According to Masterson, the pathology emerging within the framework of the Abandonment Depression Theory is rooted in the incompatibility between the true self and the false self. As a result of the repressive object—unable to tolerate separation—failing to support the child's emerging self during the process of separation and individuation, and disregarding the emotions associated with this process, the child ends up orienting towards the object's expectations rather than their own needs. This situation leads to the development of a false self-structure lacking continuity, rather than a true self with continuity (Klein, 1989). The presence of a supportive object during the process of separation and individuation is of critical importance for the formation of the true self (Masterson, 1985). An individual who receives support from their environment can realise their potential at different stages of life, whereas an individual deprived of this support attempts to gain love by conforming to others' expectations and, in this way, develops a false self (Özakkaş, 2018). The formation of the true self is not limited solely to early stages but is also possible in later stages of life. It is stated that during the transition from a false self to a true self, the individual requires self-activation. Self-activation is defined as the individual's capacity to continue pursuing their own desires—which they had previously suppressed in accordance with object expectations—in later stages of life, guided by their own decisions. However, this process can also take shape beyond the individual's control. An individual with a false self structure enters a process of construction directed towards the true self through self-activation; however, if continuity cannot be maintained during this process, abandonment depression and accompanying emotions emerge, linked to the individual's failure to receive sufficient libidinal support during the earlier stages of individuation. Masterson describes these emotions as suicidal depression, intense anger, a sense of emptiness, a feeling of meaninglessness, hopelessness, helplessness, guilt, panic and anxiety, and expresses this situation using the concept of the 'Six Horsemen of the Apocalypse' (Masterson and Klein, 1989, cited in Aydın, 2021). Individuals struggling to cope with these emotions attempt to avoid them and soothe themselves through means such as alcohol and substance use, sexual behaviours, or suicide attempts. However, these avoidance behaviours prevent the individual from re-entering the process of differentiation, thereby hindering the formation of the true self.

The Relationship Between Culture and Depression

Depression is a psychiatric disorder with a long history. Traces of this condition can be found in the Old Testament and in classical Hindu medical texts. Hippocrates identified melancholia as one of the fundamental mental illnesses more than two thousand years ago. The Anatomy of Melancholy, written by Robert Burton in 1621, remains one of the key sources consulted even today for understanding depressive disorders. In contemporary medical approaches, depression is regarded as a psychiatric condition characterised by emotional, cognitive, behavioural and physical symptoms. Although there are many concepts in the Indo-European language family that express depressive experiences, it can be difficult to find an exact equivalent for the concept of 'depression' in some non-Western societies (Sayar, 1994). This does not imply that the experience in question does not exist in those societies. The differences are more evident in the way depression is experienced by the individual, its reflection in behaviour, and the responses given at a societal level. For example, in non-Western societies, depression is frequently expressed through physical symptoms, and lower suicide rates are observed. In Western societies, however, feelings of guilt are said to be more pronounced and are associated with the Judeo-Christian cultural heritage (Kara, 1997). A classic study conducted in the Azerbaijan region of Iran revealed that sadness and grief can carry positive connotations within that culture, and that depressive affect can be associated with concepts of devotion and piety. In another study conducted by Kleinman, it was argued that the diagnosis of neurasthenia, widely used in China, is treated as a separate category despite its similarities to depression in terms of criteria, and that in a culture where the open expression of psychological distress is not socially accepted, this diagnosis serves as a unique form of expression. Although biological factors play a strong role in some types of depression, it is accepted that the behavioural expression of these biological processes may vary due to the pathoplastic effect of cultural factors. It is expected that individuals experiencing a biochemical deficit

will interpret this condition, translate their experiences into behaviour, and respond to the social reactions to these behaviours (Manson, 1996).

The way in which self-perception and emotions are defined plays a decisive role in the expression of emotional distress. Whilst in Western societies the self is largely viewed as an independent and individual structure, in non-Western societies the self is regarded as a structure that is intertwined with the environment and more flexible. This difference also influences how the experience of depression is lived. Whilst in Western societies depression is largely viewed as a process occurring within the individual's inner world, in other societies it may manifest as a process related to the individual's immediate environment. For example, an Iranian individual might complain of heartache rather than directly stating they feel down, or they might display negative attitudes towards their surroundings (Manson, 1996). Good and Kleinman note that depression and dysphoria are not merely interpreted in different ways, but are also reproduced within different social realities. Consequently, the rapid translation of research tools into local languages and their use without questioning their cultural validity leads to erroneous and artificial results. For instance, it is suggested that a diagnosis of dysthymia, which is meaningful in the West, may in some societies amount to the medicalisation of social problems. It is emphasised that feelings of hopelessness and helplessness arising in societies plagued by economic, political and health issues should be assessed as a reflection of existing social conditions rather than as an individual cognitive distortion. In such contexts, psychiatric categories may not provide sufficient explanatory power and may serve more to medicalise social problems (Sayar, 1994).

It has previously been noted that in non-Western societies, depression is more frequently expressed through physical symptoms. In many cultures, individuals' help-seeking behaviours are shaped by physical complaints. The inflexible application of Western psychiatric diagnostic and treatment approaches can lead to the neglect of psychosocial issues in societies where physical expressions predominate. In Western medicine, individuals are expected to be able to identify the source of their distress in psychological, interpersonal and social domains and to express this clearly (Kleinman, 1988). Whilst physical symptoms may accompany many psychiatric disorders, they are particularly common in depression. Some researchers link the preference for psychological expression in conveying emotional distress to the Western psychiatric understanding of human nature and emphasise that neither somatic nor psychological modes of expression is superior to the other. Furthermore, approaches that label societies preferring somatic forms of expression as 'backward' are subject to criticism. Cross-cultural research demonstrates that symptoms of depression can manifest in different ways across different societies (Marsella et al., 1985). In Kleinman's study conducted in Chinese society , it was demonstrated that the neurasthenia syndrome—characterised by a combination of energy loss and physical complaints—consists of a blend of depression and anxiety symptoms, and that whilst emotional symptoms may diminish following treatment, physical complaints may persist. In studies comparing British and Turkish patients, it was found that whilst depressed mood, pessimism and loss of interest were predominant in British patients, physical anxiety, restlessness and hypochondriacal symptoms were more pronounced in Turkish patients. In another study comparing Turkish and German patients, it was found that physical preoccupations and hypochondriacal tendencies were more prevalent among Turkish patients. In a study conducted in India, it was determined that of one hundred patients experiencing a depressed mood, only twenty-two complained directly about this condition, whilst the others primarily expressed physical symptoms. The concept of dysphoria can also carry different meanings across cultures. According to the Buddhist belief system, pain and suffering are viewed as a consequence of attachment to the world; consequently, sadness may be regarded as a stage in individual liberation. In Shia communities, however, mourning and grief are among the important elements of religious life. This situation demonstrates that it is not only the emotions themselves but also the meanings attributed to them that vary according to culture (Kleinman, 1985).

Although numerous studies have been conducted on the epidemiology of depression, the data obtained regarding ethnocultural variables remain limited. Among the reasons for this are the inability to clearly define the boundary between normal and pathological states in mood changes, the use of different diagnostic criteria across studies, the diversity of sample groups, and the insufficient consideration of different forms of depression in non-Western societies. Furthermore, the fact that the validity of existing diagnostic categories across different cultures has not been sufficiently scrutinised is also among the causes of these limitations (Kara, 1997). The lack of adequate examination of the cultural validity of self-report scales and interview methods used in research has rendered the reliability of the findings questionable. The fact that psychiatrists working in different regions have used these tools based on similar diagnostic patterns has led to the neglect of culture-specific characteristics. The universalist approach to psychiatry is criticised for failing to take cultural differences sufficiently into account and for placing excessive emphasis on commonalities. It is argued that, under the influence of biological reductionism, there has been a decline in interest in the social roots of depression, and that wide-ranging social interventions have not been sufficiently implemented (Kleinman, 1988). Furthermore, as human experiences are increasingly medicalised, even the slightest emotional states are being incorporated into clinical categories. Through concepts such as 'minor depression' ( ), even natural emotions like sadness are being pathologised. The cultural approach, however, argues that depression cannot be explained solely by biochemical processes and draws attention to the dimension of meaning in the individual's suffering.

A Cross-Cultural Perspective on Depression and A Comparison of Treatment Approaches

Depression from a Sociocultural Perspective

One of the key issues highlighted in current research within the fields of psychology and psychiatry is the insufficient consideration of a class-based perspective. Whilst the class variable has gained increasing importance in the social sciences literature in recent years, it has not received the same level of attention in psychological and psychiatric studies. Socio-economic indicators are mostly evaluated within the scope of psychosocial factors with ill-defined boundaries and are used in research as variables assumed to be independent of one another and effective at the individual level (Kaya, 2004). A similar trend is also evident in epidemiological studies related to depression. The number of studies directly addressing social class is limited, and existing findings indicate that class acts as an independent determinant encompassing other socio-economic variables (Belek, 1999).

In early studies examining the relationship between depression and social variables, the failure to adequately recognise depression among different cultural and ethnic groups within the poorer sections of society led to the mistaken perception that this illness was less common among poor individuals (Cimilli, 2001). Murphy et al. (1967) argued that depression is more closely associated with a higher socio-economic status. Similarly, Bagley (1973) suggested that the prevalence of depression increases as occupational status rises, attributing this to the stress experienced during the process of social mobility. In contrast, Bebbington (1978) argued that the prevalence of depression did not show a significant relationship with sociodemographic variables (Cimilli, 2001).

However, numerous studies indicate that mental disorders, including depression, are more prevalent among individuals from lower social classes. Two main approaches are frequently invoked to explain these findings. The first of these, the social selection approach, emphasises individual characteristics and predisposing factors in the emergence of mental disorders. The second approach, social causation, argues that poverty and conditions of low social class exacerbate mental health problems (Almeida-Filho et al. 2004). Ritscher et al. (2001) note that the social screening theory is valid in explaining cases of schizophrenia, which are more commonly observed in men, whilst the social causality approach is more explanatory for women experiencing recurrent unipolar depression. This approach is noteworthy in that it highlights the importance of class determinants of depression and gender roles.

In recent years, there has been a growing interest in the relationship between social inequalities and mental illness. Social inequalities are addressed in a way that encompasses gender roles, ethnic and racial structures, and class differences. A study conducted in Brazil by Almeida-Filho et al. (2004) found that the prevalence of mental disorders, including depression, was high among poor urban migrants. It is also noted that individuals with a low socio-economic status have lower rates of access to healthcare services (Lorant et al. 2003).

Although some researchers point to strong evidence that numerous stressors play a role in the onset of depression, they note that the relationship between social position and adverse living conditions is less clear-cut compared to other psychiatric disorders. A comprehensive meta-analysis by Lorant et al. (2003) revealed that depression is more prevalent among socially disadvantaged groups. However, it is noted that the nature of this relationship and the full extent of the impact of social inequalities remain unclear (Nicholson et al. 2007). Data on the effects of social status on depression are largely derived from the United States and Western Europe, and studies examining how this relationship manifests in different geographical regions are limited. It is emphasised that, particularly in Eastern Europe, depression plays a significant mediating role between social factors and health status. Furthermore, examining this relationship offers new perspectives that could contribute to understanding the social dimensions of depression.

It has been established that having limited social opportunities and a low level of education during childhood is associated with the prevalence of depression. Conversely, having advantageous conditions at an early age and a high level of education are considered protective factors against depression. It is stated that the impact of these social determinants on mental health manifests in different ways, particularly in Eastern European countries. The higher prevalence of depression among women should be addressed not only in terms of biological factors but also within the framework of social variables such as insufficient access to education and social opportunities. A large-scale study conducted in Poland, the Czech Republic and Russia found a strong link between social inequalities and depression in both women and men (Nicholson et al. 2007). It is stated that the rate of depression among men affected by inequality is five times higher than that of others. It is emphasised that social disparities in these countries are decisive in determining economic conditions and educational opportunities. Although higher prevalence rates are found among women, it is noted that this situation should not be limited to gender-based explanations alone (Nicholson et al. 2007).

In a study conducted in Pakistan by Hussein et al. (2004), a strong association was found between social deprivation and low educational attainment and depression. Mumford et al. (2000) suggest that low educational attainment may be a more decisive factor than poverty in Pakistan's urban areas. It has been noted that variables frequently highlighted in developed countries—such as maternal bereavement, large family size and a lack of close relationships—have a lesser impact in Pakistan. Conversely, the limited research conducted in developing countries indicates that poverty and educational attainment are more decisive factors in depression. Similar results have been obtained in studies conducted on African Americans (Ialongo et al. 2004).

It is noted that socio-economic deprivation facilitates the onset of depression, influences the course of the illness, and increases the prevalence of comorbid conditions. A study conducted in an urban area of Bangladesh indicated that somatoform, mood, and sleep disorders are the most common mental health problems (Islam et al. 2003). It has been observed that prevalence rates are higher among women compared to men. Another notable finding in this study is that mental disorders, including depression, are more

prevalent in groups with a higher socio-economic status. It was determined that the rate of depression in this group was five times higher. However, it was stated that no significant difference was found between socio-economic levels among women. These results have been attempted to be explained by factors such as biological characteristics, gender roles, inequalities and domestic violence. Furthermore, the fact that individuals living in urban areas are more exposed to socio-political and crime-related violence has also been linked to this situation. However, it is emphasised that these explanations fall short of fully accounting for the findings.

In a comprehensive review by Patel and Kleinman (2003), it was noted that the relationship between income inequality and mental disorders has not yet been fully elucidated. In industrialised countries, significant associations with depression have been identified among individuals with low incomes and those experiencing income inequality, particularly among women. Poverty exposes individuals to stressors that generate anxiety and fear, and increases feelings of insecurity. It is stated that the concept of security is linked to the continuity and stability of living conditions, and that individuals can only feel secure when these conditions are met. It is emphasised that feelings of insecurity associated with low income and loss of income are linked to mental disorders.

Findings from developing countries indicate that discrimination, unemployment and rapid social change contribute to an increase in mental disorders. Furthermore, it is noted that there is a strong link between low levels of education and the prevalence of mental illness. This is explained by the fact that malnutrition negatively affects cognitive development, leading to a decline in psychosocial functioning. The higher prevalence of depression among women is associated with factors beyond biological factors, such as gender-based issues, violence, marital problems, limited employment opportunities and a lack of social participation (Patel and Kleinman 2003).

In the Turkish context, it is stated that the social processes that have been influential since the 1980s include capitalist development in line with neoliberal policies, internal migration and unplanned urbanisation. It is noted that these processes have given rise to a new form of urban poverty (Kaygalak 2001). In Turkey, it is observed that class differences have become more complex and social tensions have increased. It is clear that these transformations have had significant effects on the mental health of individuals living in both rural and urban areas. However, it is noted that research in this field is limited and that the subject requires further investigation. Studies conducted in urban areas of Turkey have determined that prevalence rates of depression are higher than in rural areas (Güleç 1981). A study conducted in Eskişehir also found high prevalence of depression, attributing this to urban characteristics, the sample consisting solely of women, and the country's general socio-economic structure (Önen et al. 1994). A lack of knowledge about depression in Turkish society and the perception of this condition as a normal way of life are cited as factors contributing to the chronic nature of the illness. Furthermore, the inadequacy of mental health services is also considered a significant problem. It is stated that the process of urbanisation, alongside social and cultural changes and economic conditions, increases the prevalence of depression. In women, factors such as low educational attainment, limited economic independence, insufficient employment opportunities, and the need to juggle both work and domestic responsibilities are cited as increasing the risk of depression.

CONCLUSION

Although depression has evolved over time from melancholia to modern clinical definitions, it still presents a complex structure with biological, psychological and sociocultural dimensions today. Research demonstrates that whilst depression is a universal condition, the ways in which it is experienced and expressed vary significantly from culture to culture. In Western societies, depression is often defined as an individual internal process and a sense of guilt; whereas in non-Western societies, particularly in Turkish society, emotional distress is observed to be expressed through physical complaints (somatisation). This situation highlights the vital necessity of taking cultural sensitivity and local modes of expression into account during clinical diagnostic processes, to prevent misdiagnosis or the overlooking of psychosocial issues.

From a socio-cultural perspective, there is an inseparable link between the prevalence of depression and social class, educational level, and gender roles. Low socio-economic status, unemployment, migration, and the stress factors associated with urban living emerge as key variables that increase the risk of depression. In particular, the fact that depression rates among women are approximately twice as high as those among men is directly linked not only to biological predisposition but also to social inequalities such as limited access to education, a lack of economic independence, and role conflicts arising from domestic responsibilities.

Consequently, in societies such as Turkey, where traditional and modern structures are intertwined, strategies to combat depression should not be limited to individual treatment alone, but must also address social inequalities and cultural codes. The direct application of Western-centred psychotherapy approaches and diagnostic tools, without questioning their cultural validity, yields limited success. Therefore, adopting a holistic perspective in the development of mental health services—one that is aligned with the cultural fabric of society, incorporates socio-economic support mechanisms, and specifically targets at-risk groups—will be a fundamental step towards preventing the chronicity of depression.

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