

## Specific psychopathology of depressive syndromes in Poland

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*In order to understand a patient, the psychiatrist must pay attention to the cultural aspects of his/ her psychopathology. In Poland the symptoms and clinical course of depressive disorders are affected by religiousness, recent socio-economic transformation, social attitude towards psychiatric patients. For these reasons the clinical characteristics of depression include the problems of sinfulness, guilt and punishment, search for support in faith, threat to the financial situation and helplessness towards the reality, low self-esteem associated with the identity crisis and „embarrassment” about the disease, frequent somatization of the symptoms.*

*Key words:* depression, specific psychopathology

### Introduction

In order to know and understand a patient, the psychiatrist has to take into account cultural and psychosocial factors. Clinical characteristics of psychiatric disorders are affected by the environment in which the patient has been growing, his roots, system of values and beliefs, life philosophy, tradition handed down from generation to generation. All this is a derivative of cultural heritage in which the patient's personality develops.

On the other hand the therapist cannot rule out everyday life conditions which determine the patient's prospects. These life conditions include for instance the economic status, employment possibilities or social attitude toward psychiatric patients.

At the threshold of the 21st century when the world becomes the global village there is a general tendency to simplify and unify all systems. This tendency is also observed in psychiatry – not unreasonably experts work all the time on optimisation of international classification systems, and the motto of the 10th World Congress was “one world, one language”. However, taking into account the above-mentioned factors, especially in psychiatry one should bear in mind the cultural aspects of psychopathology.

Depressive disorders are an important and interesting subject for analysis of this problem. Firstly, they are most common. In the age of “melancholy” the number of depressive episodes increases, and the number of affected persons seeking medical

advice also rises.

Secondly, the style of thinking and system of beliefs of the patient about himself or herself, the surrounding world and the future has been found to play an important role in the development and course of depression. According to the cognitive concept formulated by Aaron Beck the cognitive patterns and beliefs formed since the childhood become dysfunctional in depressive patients making them susceptible to depression and maintaining depressive symptoms. The cognitive patterns are formed both as a result of life experience and opinion imparted by parents and teachers, as well as the culture specific ways of how the world is interpreted.

This is where the specificity of depression among the Poles and factors related to its development should be discussed.

### **Depression in Poland**

Poland is a catholic country, in which the Church has actually ruled for ages.

Religiousness to a great extent has determined the way of thinking and system of beliefs.

Priests have frequently been assigned the role of important persons or psychotherapists. People with their sorrows and fears have usually turned not to physicians or psychologists but to their confessors, frequently not familiar with psychopathology and thus enhancing the depressive feeling of guilt.

Low self esteem, feeling of sinfulness, guilt and punishment are closely correlated with the development of major depression. Papers published towards the end of the 80ies indicated a relationship between religiousness in its broad sense and the feeling of guilt. We observe intuitively this problem in routine work with depressive patients. While talking to the patients they frequently refer to sin, and make an in-depth analysis of offences (especially women who had an abortion or use contraceptive methods forbidden by the Church). Believers have a deep feeling of guilt aroused by the inability to pray and lost contact with God. Such patients frequently await the punishment from God they deserve for the fact of being depressive or they treat suicidal ideas as a deadly sin. According to Prof. Maria Jarosz from the Institute of Political Sciences PAN "traditional Polish Catholicism – although certainly preventing from autodestructive behaviours – is not effective enough, since fatal suicides have increased by 280% in the last 45 years".

A depressive feeling of guilt appears also in the context of sexuality, until recently under a taboo. It is common that the patients usually do not talk spontaneously about their problems in sexual life, rarely and unwillingly complain of sexual dysfunction. For that reason, sexual disorders related to depression are underestimated or even neglected as a clinical problem in Poland.

On the other hand according to many patients faith provides an important support in their illness. Trust in God is an attitude, which helps them to survive. Antoni Kępiński said, "those who believe have more life dynamics than those who do not. Apart from an activating influence faith is also a systematising factor. It forms a hierarchy of values, which helps people to regulate their exchange of information with

the surrounding world”.

Commitment to religion assures also the support of a community, not only in the sphere of spiritual life, but also in solving concrete problems (for instance family, professional, financial problems).

Such help is especially important in relation to transformation Poland undergoes in recent years. The beginning of the 80ies was a time of great enthusiasm and high hope in response to the formation of “Solidarity”. The rate of suicides decreased by 35% at that time. Then the Poles were under marshal law and in the beginning of this decade they again started to cherish hopes associated with new reforms. The economic reform in the country meant an abrupt change in the financial situation of the society – some people rapidly made money whereas others became poor. Maria Jarosz describes well the state of the society: “Each change in the social status determining money, power and prestige is a source of major emotions modulating people’s behaviour. The inability to occupy a desired social position gives rise to a sense of wrong and frustration, the stronger the higher the degree of aroused expectations. An equal chance, one of the signposts of social and educational policy, gradually became illusory – disappointing the young in their hopes (...). This gave ground to a number of social attitudes and behaviours: revolutionary, accelerating the desired direction of changes, and deviant (including autodestructive)”.

Unemployment has become a new phenomenon for most Poles. This problem is especially difficult for farm workers and people living in small villages, which is reflected in an abrupt rise of the suicide rate in these social groups.

Socio-economic transformation is bound to affect the psychopathology of depression in Poland. After therapy, the patients even with complete remission frequently face the problem of losing work. Employers do not hesitate to say, “you’d rather obtain a pension”. This increases the disability rate, especially among women who are less willingly employed. Catamnestic studies among patients admitted to the Department of Adult Psychiatry with a diagnosis of endogenous depression revealed that almost 40% were on permanent or temporary pension (including 60% of women), although a 1– to 5-year follow-up demonstrated complete remission in 50%, and only short-term relapses treated on the out- patient basis in further 20%. On the other hand, out of fear of further impoverishment of the family, some people on pension, especially men take on additional jobs, frequently worse and poorly paid. The deterioration of the financial situation due to illness is most frequently reported by the patients and their families. For these reasons the psychopathological characteristics of depressive patients include a sense of danger to the family’s existence and no prospects for future as well as a sense of helplessness in coping with the reality.

Recent transformation has had a profound influence not only on the financial sphere, but also caused an identity crisis. Depressive patients, especially the elderly, face this problem when summarising their life. It appears that the values they used to believe in and live for suddenly depreciated and lost their importance. In turn young people need authorities they can respect. At time of reflection the problem of self esteem must appear, which is especially low from the depressive viewpoint.

The pattern of depression in the elderly includes the problems of World War II and

Nazi occupation as well as experiences related to imprisonment in German concentration camps and Soviet labour camps. Not accidentally depressive syndromes are most frequent in the former prisoners. These syndromes are characterised by sleep disorders with nightmares about camp life, a sense of harm for the injury and lost youth, sometimes a feeling of guilt and a negative opinion of the then attitudes. At present it is impossible to distinguish to what extent the patients reflecting on their past represent depressive thinking and indisputable facts.

Nevertheless these depressive syndromes require specific approach and comprehensive treatment.

Another problem is a prejudice against psychiatric patients, still present in our society. Hospitalised patients are afraid of the attitude of their neighbours and friends, they are ashamed of their disease. Stigmatization and social isolation is also painful to the patients' families, especially in rural communities and in small villages. For that reason an appointment with a psychiatrist is frequently a secret, and an eventuality. Depressive patients usually refer to other specialists first. They report various somatic complaints (fatigue, insomnia, no appetite, pain, chest discomfort, etc.), which is easier to do than talk about sorrow. That is why depression is diagnosed late, the patient is referred to a psychiatrist after several failed attempts to cure him or her (usually with sedatives or antidepressants in too low doses, used for a short time and frequently replaced with new agents). Perhaps a fear of confessing psychiatric problems is a factor favouring somatization of the symptoms.

### Conclusions

In order to understand a patient, the psychiatrist must pay attention to the cultural aspects of his/ her psychopathology. In Poland the symptoms and clinical course of depressive disorders are affected by religiousness, recent socio-economic transformation, social attitude towards psychiatric patients. For these reasons the clinical characteristics of depression include the problems of sinfulness, guilt and punishment, search for support in faith, threat to the financial situation and helplessness towards the reality, low self esteem associated with the identity crisis and "embarrassment" about the disease, frequent somatization of the symptoms.

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