

From mind to body: how culture shapes depression

Da mente ao corpo: como a cultura molda a depressão

De la mente al cuerpo: cómo la cultura influye en la depresión

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Abstract:

Objective: to critically analyze how culture shapes the clinical and symbolic expression of depression and to discuss its implications for the practice of cross-cultural nursing. **Methods:** a narrative review without temporal restriction, of a reflective and interpretive nature, conducted in the PubMed, Scientific Electronic Library Online, and Latin American and Caribbean Health Sciences Literature databases in December 2025. Theoretical and empirical studies addressing cultural, symbolic, and communicational dimensions of depression were included, with an emphasis on cross-cultural comparisons. The analysis followed a comprehensive and comparative reading, organized into four axes: psychological versus somatic manifestations; acculturation and identity; religiosity and corporeality; and implications for nursing care. **Results:** seven articles were considered, organized into four blocks: *Latin America and Europe: between mind and body, reason and affection; Africa and Europe: the corporeality of suffering and cosmologies of balance; North America and Asia: cultural alexithymia, emotional regulation, and acculturation; Russia and Australia: social support, resilience, and cultural meanings of suffering*. Consistent patterns of cross-cultural variation in the expression of depression were identified. Western societies tend towards the psychologization of suffering, while Asian, African, and Latin American societies express emotional pain through the body and spirituality. Acculturation proved to be an ambivalent factor, capable of intensifying symptoms or generating new forms of symbolic adaptation. Ethnic identity and social support emerged as protective factors. **Conclusion:** depression is an experience shaped by cultural values and languages. Recognizing this diversity allows cross-cultural nursing to offer more empathetic, dialogical, and culturally competent care, integrating biological, spiritual, and community dimensions of human suffering.

Keywords: Depression; Culture; Mental Health; Transcultural Nursing.

Resumo:

Objetivo: analisar criticamente como a cultura molda a expressão clínica e simbólica da depressão e discutir suas implicações para a prática da enfermagem transcultural. **Método:** Revisão narrativa sem restrição temporal, de caráter reflexivo e interpretativo, realizada nas bases PubMed, Scientific Electronic Library Online e Literatura Latino-Americana e do Caribe em Ciências da Saúde em dezembro de 2025. Foram incluídos estudos teóricos e empíricos que abordassem dimensões culturais, simbólicas e comunicacionais da depressão, com ênfase em comparações transculturais. A análise seguiu leitura compreensiva e comparativa, organizada em quatro eixos: manifestações psicológicas versus somáticas; aculturação e identidade; religiosidade e corporeidade; e implicações para o cuidado de enfermagem. **Resultados:** foram considerados sete artigos organizados em quatro blocos: *América Latina e Europa: entre mente e corpo, razão e afeto; África e Europa: corporalidade do sofrimento e cosmologias de equilíbrio; América do Norte e Ásia: alexitimia cultural, regulação emocional e aculturação; Rússia e Austrália: apoio social, resiliência e significados culturais do sofrimento*. Identificaram-se padrões consistentes de variação transcultural na expressão da depressão. Sociedades ocidentais tendem à psicologização do sofrimento, enquanto asiáticas, africanas e latino-americanas expressam a dor emocional por meio do corpo e da espiritualidade. A aculturação mostrou-se fator ambivalente, capaz de intensificar sintomas ou gerar novas formas de adaptação simbólica. Identidade étnica e apoio social emergiram como fatores protetores. **Conclusão:** a depressão é uma experiência moldada por valores e linguagens culturais. Reconhecer essa diversidade permite à *enfermagem transcultural* oferecer cuidados mais empáticos, dialógicos e culturalmente competentes, integrando dimensões biológicas, espirituais e comunitárias do sofrimento humano.

Palavras-Chave: Depressão; Cultura; Saúde Mental; Enfermagem Transcultural.

Resumen:

Objetivo: analizar críticamente cómo la cultura moldea la expresión clínica y simbólica de la depresión y debatir sus implicaciones para la práctica de la enfermería transcultural. **Método:** Revisión narrativa sin restricciones temporales, de carácter reflexivo e interpretativo, realizada en las bases de datos PubMed, Scientific Electronic Library Online y Literatura Latinoamericana y del Caribe en Ciencias de la Salud en diciembre de 2025. Se incluyeron estudios teóricos y empíricos que abordarían las dimensiones culturales, simbólicas y comunicativas de la depresión, con énfasis en las comparaciones transculturales. El análisis siguió una lectura exhaustiva y comparativa, organizada en cuatro ejes: manifestaciones psicológicas frente a somáticas; aculturación e identidad; religiosidad y corporeidad; e implicaciones para la atención de enfermería. **Resultados:** se consideraron siete artículos organizados en cuatro bloques: *América Latina y Europa: entre mente y cuerpo, razón y afecto; África y Europa: corporalidad del sufrimiento y cosmologías del equilibrio; América del Norte y Asia: alexitimia cultural, regulación emocional y aculturación; Rusia y Australia: apoyo social, resiliencia y significados culturales del sufrimiento*. Se identificaron patrones consistentes de variación transcultural en la expresión de la depresión. Las sociedades occidentales tienden a la psicologización del sufrimiento, mientras que las asiáticas, africanas y latinoamericanas expresan el dolor emocional a través del cuerpo y la espiritualidad. La aculturación se reveló como un factor ambivalente, capaz de intensificar los síntomas o generar nuevas formas de adaptación simbólica. La identidad étnica y el apoyo social surgieron como factores protectores. **Conclusión:** la depresión es una experiencia moldeada por valores y lenguajes culturales. Reconocer esta diversidad permite a la *enfermería transcultural* ofrecer cuidados más empáticos, dialógicos y culturalmente competentes, integrando las dimensiones biológicas, espirituales y comunitarias del sufrimiento humano.

Palabras clave: Depresión; Cultura; Salud Mental; Enfermería Transcultural.

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INTRODUCTION

Depression can be understood as a complex human phenomenon, whose lived experience and clinical expressions are heterogeneous¹, resulting from the interaction of biological, psychological, and social factors².

However, the clinical perspective continues to be frequently conditioned by a biomedical and universalist framework; an example of this is found in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which organizes diagnosis based on universal criteria of symptoms and duration³, facilitating clinical standardization but ignoring its cultural roots. Emotional suffering is mediated by beliefs, values, languages, and symbolic systems that shape its expression, social legitimation, and ways of seeking help. Culture acts not as a passive backdrop, but as a structure of meaning that guides how psychic pain is experienced and communicated⁴.

From a care perspective, this is not just a conceptual debate: in mental health, the way suffering is narrated, interpreted, and legitimized conditions the therapeutic relationship, adherence, and access to care strategies. For this reason, Transcultural Nursing brings the need for culturally congruent practices, capable of adjusting language, communication, and interventions to the beliefs, values, and meanings attributed by the patient to their depressive experience⁵.

Thus, the present study aims to critically analyze how culture shapes the clinical and symbolic expression of depression and discuss its implications for the practice of transcultural nursing.

METHODS

This is a narrative review, with a reflective and interpretive character, intended to explore how different cultures shape the clinical and symbolic expression of depression. The narrative review prioritizes analytical breadth and critical dialogue between evidence, and the adoption of methodological rigor in its production and evaluation is recommended, according to contemporary guidelines⁶.

The search included studies available in the PubMed, SciELO, and LILACS databases, using the descriptors: "Depression", "Culture", "Mental Health", "Transcultural Nursing", "Somatization", and "Acculturation", without temporal restriction, in Portuguese, English, and Spanish that addressed cultural, symbolic, or communicational aspects of depression. The search and extraction/organization of the studies took place in December 2025.

The interpretative reading of the studies followed an analytical-comparative path, allowing the identification of regularities and contrasts between sociocultural contexts, proposing a theoretical reflection on depression as a cultural phenomenon, as well as addressing how different sociocultural contexts modulate the clinical and symbolic expression of suffering and the implications of this understanding for the practice of transcultural nursing.

RESULTS

This study included 7 articles, published between 2000 and 2021, predominantly comparative cross-cultural investigations and analyses on the cultural expression of depression, interpreted in light of four axes of reflection: 1) psychological versus somatic manifestations; 2) acculturation and cultural identity; 3) religiosity, corporeality and symbolism of suffering; and 4) implications for care and the practice of cross-cultural nursing.

Chart 1. Studies included on culture and depression between 2000 and 2021. Valencia, Spain, 2025.

Autor (Ano)	País/Contexto cultural	Tipo de estudo	Tema principal
Guerrero Escusa (2014) ⁷	Spain/Cuba	Comparative	Somatic vs. psychological expression
Heerlein et al. (2000) ⁸	Chile/Germany	Comparative	Cultural dimensions of depression
Oliveira et al. (2012) ⁹	Brazil/Europe	Transcultural	Ethnic identity and well-being
De la Torre-Luque et al. (2020) ¹⁰	Nigeria/Spain	Comparative	Symptom networks
Ryder et al. (2008) ¹¹	China/USA	Transcultural	Somatization
Cheung et al. (2020) ¹²	Asian migrantes	Longitudinal	Acculturative stress
Demutska & Kiropoulos, (2021) ¹³	Russian speakers/Australia	Migratory	Social support

The results were organized into four geographic and analytical blocks for comparison between models of subjectivity and their clinical repercussions: *Latin America and Europe: between mind and body, reason and affection; Africa and Europe: the corporeality of suffering and cosmologies of balance; North America and Asia: cultural alexithymia, emotional regulation, and acculturation; Russia and Australia: social support, resilience, and cultural meanings of suffering.*

The analysis identified consistent patterns of cross-cultural variation in the expression of depressive symptoms, as well as underlying sociocultural mechanisms that modulate the experience of suffering.

Latin America and Europe: between mind and body, reason and affection

A study comparing populations from Spain and Cuba observed that, while Spanish participants tended to express suffering in a cognitive-affective way with an emphasis on guilt, hopelessness, and discouragement, Cuban participants manifested somatic symptoms, such as insomnia, weight loss, and decreased sexual desire⁷. This difference goes beyond medical language: it translates distinct ways of constructing pain and the self. In Iberian and Latin American cultures, strongly marked by Catholicism, collectivism, and social inequality, it is inferred that the body assumes a political and symbolic role in the expression of suffering, functioning as a territory of resistance and affective communication.

In another cross-cultural comparison between Chile and Germany, similar psychometric patterns were identified, but underlying existential divergences: Chilean participants reported greater social isolation and spirituality as a coping mechanism, while German participants associated depression with dimensions of performance and individual autonomy⁸. These contrasts may reflect different cultural matrices of subjectivity: a more rationalistic and introspective model, and another more relational and symbolic one.

An exploratory study in Brazil and Europe showed that a robust ethnic identity – understood as awareness of cultural belonging and appreciation of one's own roots – was associated with greater psychological well-being⁹. Identity, in this context, tends to act as an affective and narrative anchor, mitigating the impact of globalization and cultural homogenization on mental health.

These studies indicate that, in Latin American contexts, depression is not reduced to psychic interiority; it is lived and performed collectively, intertwining political, spiritual, and family dimensions. For Nursing, understanding these nuances means recognizing the body and the word as spaces of cultural negotiation, through which care needs to integrate listening, empathy, and respect for the symbolic diversity of emotions.

Africa and Europe: the corporeality of suffering and cosmologies of balance

A cross-cultural comparison of major depression symptom networks in older adults in Nigeria (Yoruba ethnic group) and Spain revealed a greater tendency toward somatization in the African context and a predominance of psychological symptoms in the Spanish context¹⁰. This difference should not be read merely as linguistic or educational variation, but as a reflection of distinct cosmologies of health and illness.

In many African contexts, health is understood as a state of balance between physical, spiritual, and community dimensions; the body is the point of convergence of vital and social forces. Emotional suffering, therefore, is often expressed through bodily imbalances, such as

fatigue, internal heat, diffuse pain, which relate to the disruption of this harmony. In this holistic view, the body is not separate from the soul, but a symbolic means of communication with the spiritual and social world⁴.

This model contrasts with the European biomedical paradigm, which tends to segment suffering into mental or physical categories. This epistemological difference has profound clinical implications: when healthcare professionals interpret these complaints only as somatic symptoms, they risk delegitimizing the cultural meaning of suffering¹⁰.

For transcultural nursing, recognizing the embodied nature of suffering is essential to providing dialogical and culturally congruent care, capable of integrating local beliefs about energy, spirituality, and family relationships into the therapeutic process.

North America and Asia: cultural alexithymia, emotional regulation, and acculturation

A cross-cultural investigation identified that Chinese populations tend to somatize depressive symptoms, manifesting suffering through physical pain, fatigue, or a feeling of body heaviness, while North American populations more openly verbalize negative emotions such as sadness and hopelessness¹¹. This significant difference reflects not only a linguistic contrast but also divergent cultural models of mind and body.

A longitudinal study indicated that acculturative stress, in the case experienced by migrants when trying to reconcile values of origin and norms of the host society, tends to increase the incidence of depressive symptoms, with a mediating role played by aspects related to emotional regulation¹².

These findings indicate that acculturation produces not only suffering but also new hybrid forms of emotional expression, in which cognitive and somatic elements coexist. "Cultural alexithymia"¹¹ can therefore be understood as an adaptive mechanism for social survival, and not as an affective deficit. For transcultural nursing, understanding these differences is essential to avoid misdiagnosis and to promote interventions that respect the symbolic language of the body and the sociocultural context of the patient.

Russia and Australia: social support, resilience, and cultural meanings of suffering

In migratory contexts, an analysis with native Australians, Russian-speaking immigrants, and resident Russians found a lower prevalence of depression and anxiety among Russian speakers who migrated to Australia, attributing this finding to the role of community social support and cultural collectivism¹³.

Among Russian speakers, suffering is often reframed as a sign of moral resistance and spiritual strength, rooted in a tradition that values overcoming and sacrifice. This ethos of cultural resilience contrasts with the individualistic Western model, in which suffering tends to

be medicalized. The maintenance of cultural ties and family rituals acts as a protective mechanism against the adversities of acculturation, reducing feelings of alienation and social isolation¹³.

Transcultural resilience does not derive solely from individual traits, but from collective systems of support and meaning¹³. For nursing, understanding these nuances is essential: care strategies that incorporate community values and symbols of resistance can promote therapeutic adherence and emotional empowerment of migrant patients.

DISCUSSION

Depression cannot be understood as a universal or homogeneous phenomenon. The lived experience and clinical expression of the disorder vary widely across contexts, including somatic patterns, trajectories of illness, and ways of communicating suffering¹. Complementarily, comparative psychometric analyses indicate that the very organization of symptoms may differ among large cultural groups, suggesting variations in how symptoms cluster and relate¹⁴.

In Latin American and Mediterranean populations, psychic pain tends to be embodied and relational: suffering is shared and narrated through the body, relationships, and everyday religiosity. In societies such as Cuba and Chile⁷⁻⁸, the spiritual and communal dimension of suffering takes center stage, contrasting with the more introspective and rationalized European pattern. In these contexts, the body functions as a symbolic mediator between emotion and collectivity, and somatic expression is socially recognized as legitimate. A Brazilian study⁹ reinforces this idea by demonstrating that strengthening cultural and ethnic identity protects against depressive symptoms by offering meaning and belonging in times of globalization and social disruption.

In sub-Saharan Africa, research¹⁰ observed that suffering is articulated from cosmologies of balance, in which health and illness result from the harmony between body, spirit, and community. The disruption of this order generates bodily manifestations that, from a Western biomedical perspective, could be interpreted as somatization, but which, in fact, constitute coherent cultural discourses about malaise. This holistic view contrasts with the mind-body dualism that can dominate Western psychiatry and broadens the interpretative horizon of care.

Studies with Asian and migrant populations reinforce this expressive diversity, which manifests itself both through emotional restraint (“cultural alexithymia”)¹¹ – which, far from representing repression, fulfills the social function of preserving harmony – and through acculturative stress (the effort to reconcile the values of origin with the norms of the host

society)¹², which can intensify depressive symptoms, especially when adequate resources for emotional regulation are lacking. At the same time, these acculturation processes generate hybrid forms of suffering, in which somatic and verbal expression coexist, revealing the cultural plasticity of the human mind.

In migratory contexts¹³, the experience of depression is traversed by the sense of belonging and support networks. Among Russian speakers in Australia, community cohesion and cultural collectivism were associated with lower levels of depression and anxiety, favoring a narrative of resilience and moral resistance in the face of adversity. Suffering, reinterpreted as a sign of strength and dignity, ceases to be a stigma and becomes a way of affirming identity. These findings also suggest that social factors such as isolation, discrimination, and loss of support networks can act as chronic stressors, influencing both subjective experience and physiological mechanisms related to illness.

At the same time, considering depression as a cultural phenomenon does not imply denying biology. The participation of neuroimmunoendocrine and inflammatory pathways is associated with the course and intensity of depressive symptoms, especially in contexts of chronic stress and physiological vulnerability¹⁵. This explanatory level helps to understand why manifestations such as fatigue, sleep disturbances, and anhedonia can have variable expression; however, it remains insufficient when dissociated from the cultural meaning of suffering and the social conditions that modulate the depressive experience.

From this perspective, the implications for nursing are direct. If the presentation of suffering and the search for help depend on beliefs, values, language, and spirituality, mental health care requires cultural sensitivity and communicative competence. Transcultural Nursing provides a framework for interpreting depression as a situated experience and guiding culturally congruent interventions throughout the care process, favoring empathetic listening, symbolic translation of suffering, and therapeutic negotiation compatible with the patient's meanings⁵. Promoting spaces for dialogue between paradigms – biomedical, spiritual, and community – can contribute to a more humane, plural, and clinically responsive practice, without reducing suffering to biochemistry or relativizing it as a mere social construct.

Understanding depression as a cultural phenomenon broadens clinical precision, improves the quality of care, and strengthens nursing as a bridge between different ways of making sense of psychic pain. Integrating sociocultural determinants and biological knowledge into a broader explanatory framework allows for a more adequate response to the patient's needs and the real complexities of human suffering.

CONCLUSION

The synthesis of the findings shows that major depression is a global phenomenon with local expressions, modulated by cultural values, symbolic languages, and structures of belonging. In Western societies, the psychologization of suffering prevails; in Latin American, African, and Asian contexts, bodily and spiritual communication of pain predominates.

Acculturation emerges as an ambivalent process. It can intensify symptoms when associated with stress and loss of references, but it can also generate hybrid forms of adaptation. Conversely, ethnic identity and social support prove to be protective factors, reinforcing the role of the community and networks of meaning in preserving emotional well-being.

For Nursing, understanding this diversity implies developing a transcultural practice based on empathetic listening, validating local modes of expressing suffering, and integrating biomedical therapy, spirituality, and community resources.

Because this is a narrative (non-systematic) review, the selection and synthesis of studies may be subject to search and interpretation bias, without any claim to exhaustiveness or formal assessment of the risk of bias. Furthermore, some of the references used are classic and older, as they constitute a conceptual and historical foundation for the debate on depression and culture. Even so, the need for continuous updating in future versions and in empirical research that deepens the interface between cultural determinants and the clinical expression of depression is recognized.

In turn, in theoretical terms, recognizing depression as a cultural construct broadens the epistemological scope of mental health and reaffirms nursing's ethical commitment to comprehensive and culturally competent care.

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