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3 Cross-Cultural Studies of Depression

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CROSS-CULTURAL ASPECTS OF DEPRESSION: INTRODUCTION

In this chapter we examine key questions that arise from a cross-cultural approach to the study of depression. Several authors have noted that cross-cultural epidemiological data on depression share unsubstantiated assumptions about the cross-cultural validity of the concept depression and of associated epidemiological instruments (e.g., Marsella et al., 1985). Anthropological research suggests that models of depression based on studies of patients in Western psychiatric settings cannot be unquestioningly generalised to non-Western societies. Although some forms of depression may be found in all populations, it may not be valid to equate forms of the illness manifested primarily in psychological terms associated with strong feelings of guilt or remorse with illness experienced primarily in somatic terms.

Fundamental to the question of the cross-cultural validity of depression as a distinct psychiatric disorder is a critical appraisal of dichotomous mind-body approaches to psychological and somatic manifestations of depression. Contemporary DSM-III-R psychiatry defines depression as a mood disorder with associated somatic symptoms, and thus presupposes a dichotomous mind-body approach to psychological and somatic manifestations of depression. Insofar as this dichotomous approach distinguishes psyche and soma, it reproduces assumptions of Western thought and culture, which must from the outset be suspended in formulating a valid comparative stance.

Our review begins with consideration of cultural variation in dysphoric affect and the import of such variation for universalist definitions of depressive disorder. We examine cross-cultural evidence on somatic components of depression and explore the concept of somatization in relation to depression and the communication of distress. In the second part of our discussion, we review the evidence of cross-cultural variation in depressive symptomatology (Marsella et al., 1985). Observation of striking cultural and social class variations in symptoms is frequently used to support the view that culture affects the content but not the process or structure of psychopathology. We argue that culture is of profound importance to the experience of depression, the construction of meaning and social response to depressive illness within families and communities, the course and outcome of the disorder, and thus to the very constitution of depressive illness. This anthropological perspective is presented through examination of a series of theoretical, substantive, and methodological issues. In particular, we review the social and cultural contexts within which depression originates, examining the role of gender, social class, family relations, migration, political violence, and social change. Finally, we suggest directions for future research.

THE CULTURAL CONSTRUCTION OF EMOTION

Although the cross-cultural study of depression and depressive affect invariably presupposes a theory of emotion, it is by no means certain that emotions are constituted the same way in different cultures. We begin this section by briefly summarising an anthropological perspective on emotion, and then set forth issues central to the cross-cultural study of depression: (1) the ethnopsychology of emotion; and (2) culturally distinctive meanings associated with dysphoric emotions.

To the extent that emotions have been considered shared or common experiences of individuals across culturally distinct settings, they have generally been assumed similar on the basis of universal, innate human propensities (Ekman, 1982; Isard, 1977; Plutchik, 1980; Wierzbicka, 1986). If culture is acknowledged as a factor in emotional life, it is only as a second-order interpretation of such innate qualities (Levy, 1984). In addition, thought and emotion are cast as largely separate, mutually exclusive categories: "the cultural/ideational and individual/affective have been construed as theoretically, and empirically, at odds" (Rosaldo, 1984, p. 139). Against this common scholarly assumption we argue here for an approach to emotion as an essentially cultural integration of bodily experience and communication.

Given the (empirically unproven) assumption of biological similarity of emotional states, we need to consider cultural sources of similarity and variation. This point has been advanced by Geertz (1973), who asserted that "not only ideas, but emotions too, are cultural artifacts" (p. 81). Emotions can be consid-

ered as essentially cultural since no human response or experience occurs in the absence of culturally defined situations or meanings. It is particular situations or contexts that provide the basis for emotions and "the determination of when one ought to be angry, when sad, when sorry, when lonely, and how to act, is largely a cultural matter" (Myers, 1979, p. 349).

Anthropologists and cross-cultural psychologists have argued that affects are inseparable from cultural systems of meaning. Culture organizes the experience and interpretation of loss here as the sting of desperate grief, there as ambivalent silence, elsewhere as concatenations of feelings—guilt with sadness, rage with hopelessness, fear of sorcery with calm acceptance of fate—that hold special salience (and in some cases arguably may only be felt) in particular social systems. The documentation for this conclusion is impressive; the processes responsible for its occurrence and their implications for the epidemiology and phenomenology of depressive disorders are only now receiving serious attention (Geertz, 1980; Good & Good, 1982; Kleinman & Good, 1985; Lutz, 1985, 1988; Marsella, DeVos, & Hsu, 1985; Myers, 1979; Rosaldo, 1983; Schieffelin, 1983; Shweder & LeVine, 1984; White & Kirkpatrick, 1985).

THE ETHNOPSYCHOLOGY OF EMOTION

An essential step toward culturally informed models of depressive disorders is the investigation of indigenous or ethnopsychological models of dysphoric affects. Ethnopsychological themes include factors such as the relative ego-centricity of the self; indigenous categories of emotion; the predominance of particular emotions within societies; the inter-relations of various emotions; identification of those situations in which emotions are said to occur; and ethnophysiological accounts of bodily experience of emotions. This constellation of sociocultural features will mediate how persons experience and express depression and other emotions.

Conceptions of emotion are embedded within notions of self, which have been characterized as varying along a continuum between "egocentric" and "socio-centric" (Shweder & Bourne, 1984). Individuals with a more sociocentric sense of self are considered to be more relationally identified with others than are individuals with a more *egocentric* sense of self, who view themselves as more or less unique, separate persons. The former have often been associated with non-Western cultural traditions, the latter with more industrialized nations (Geertz, 1984). The Pintupi aborigines of Australia provide an examplary case of a culture in which the conception of self is essentially kin-based (Myers, 1979). Similar claims of the primacy of family definitions of self have been made for Hispanic populations (Murillo, 1976). This tendency stands in notable contrast to middle class Caucasion Americans, for example, for whom self-identity, while family-related, is constituted more as a distinct individual who stands apart from

others. While these characterizations of the self index general differences in broad cultural axes, it is important to note that as generalizations they over-simplify the construction of the self, failing to specify particular domains and settings across which selves may be differentially constituted within a culture.

An understanding of emotions as intrapsychic events, feelings or introspections of the individual is a specifically Western definition. A case contrast to emotion as introspective feeling state has recently been provided by Lutz (1985, 1988) in her studies of the Ifaluk of Micronesia. For the Ifaluk, cultural categories of thought and emotion are not strongly differentiated. Moreover, emotions are not located within persons, but in relationships between persons or within events and situations. *Metagu* (fear/anxiety), for example, is said to occur in response to a superior's justifiable *song* (anger) over the breach of a cultural taboo, the situation of being in an open canoe in shark-infested waters or the occurrence of ghost activity. (It is important to note, however, that emotion, for the Ifaluk *is* sometimes experienced and defined as "about our insides.") Dysphoria or depression may thus be experienced as a predominantly intra-psychic mood disorder of individuals in more social and contextual terms (Toussignant, 1984).

Differing cultural interpretations of self and emotion may therefore lead to one of the most important aspects of emotional life: variations in the qualitative features of bodily/emotional experience. Dysphoric affects cannot properly be considered as basically "the same" cross-culturally: there are culturally distinctive repertoires of distressing experience. For example, Ebigbo (1982, p. 29) found that "Mentally ill patients in Nigeria and indeed in West Africa very often complain of various types of somatic distress. These complaints are made independently of the diagnosis of the mental illness and whether or not it is very acute. Examples of such psychosomatic complaints are: heat in the head, crawling sensation of worms and ants, headache, heaviness sensation in the head, biting sensation all over the body, etc." Among a Mexican-descent population, Jenkins (1988a, 1988b) found that indigenously labeled conditions of *nervios* incorporate a variety of somatic complaints, including "brainache," or the sensation that the brain is "exploding" or "uncontrollable." These complaints stand in stark contrast to those commonly recognized among European and North American populations.

Emotion states not only vary in relation to self-concept, they are also elaborated in light of cultural knowledge. Entire domains of emotional life may be either culturally and experientially elaborated or unelaborated. This has been particularly documented for the emotion of anger. For example, while the Eskimos (Briggs, 1970) virtually never display anger, the Kaluli of New Guinea (Schieffelin, 1983) and the Yanomamo of Brazil (Chagnon, 1977) have highly elaborated, culturally sanctioned displays of anger. Among the Tahitians studied by Levy (1973), an important societal rule is the inhibition of anger. According to Levy these Society Islanders in fact seldom experience anger (Levy, 1973).

This is no less true of appropriate displays of profound sadness and sorrow, some cultures encourage such expressions (for example, Iranian culture) while others evidence little tolerance of these affects. Furthermore, within a culture, social class influences how particular emotions are communicated. Chinese villagers may express sadness publicly, but middle class, formally educated Chinese will not do so outside of close family relations. In addition to fundamental differences in cultural emphases on particular emotions, such states may also vary in affective intensity and meaning. Some societies (e.g., Amazonian Yanomamo) may foster intense emotional involvement, whereas others (e.g., the Javanese) may encourage inner states of "smoothness" and calm (Chagnon, 1977; Geertz, 1973).

Cross-cultural studies of the socialization of affect have documented that differences in emotional emphases are deeply rooted in the developmental make-up of cultural members (Ochs & Schieffelin, 1985). As noted by H. Geertz (1959), socialization of affect selects for a cultural repertoire or "vocabulary of emotion":

> Every cultural system includes patterned ideas regarding certain interpersonal relationship and certain affective states, which represent a selection from the entire potential range of interpersonal and emotional experiences. The child, growing up within the culture and gradually internalizing these premises, undergoes a process of socially guided emotional specialization. He learns, in a sense, a special vocabulary of emotion. (p. 225)

Cultural specialization in emotional life again raises the possibility of whether emotions, unknown to us, are part of the everyday experience of members of culturally distinct societies.

A common assumption is that depression can be conceived on a continuum, as mood, symptom, or disorder (see Kleinman & Good, 1985). That there is a clear cutoff point between normal dysphoria and pathological depression has never been definitively demonstrated for our own culture. There is even less empirical reason to believe that it is identical across cultures. Partly for this reason, indigenous concepts of dysphoric affect cannot be so neatly partitioned from psychiatric definitions of depressive disorder.

CULTURE AND DEPRESSIVE AFFECT

Dysphoria—sadness, hopelessness, unhappiness, lack of pleasure with the things of the world and with social relationships—has dramatically different meaning and form of expression in different societies (Kleinman & Good, 1985, p. 3). The suffering of individuals appears against the background of cultural images of suffering. Gaines and Farmer (1986) review the cultural system of

meaning that identifies individuals who suffer as exemplary heroes in Mediterranean culture. Obeyesekere (1985) points out that suffering is a permanent positively valued feature of cosmology in Buddhist cultures. Good, Good, and Moradi (1985) demonstrate that suffering is a highly elaborated religious element associated with martyrdom and grief for Shi'ite Muslins. Tousignant (1984) and Jenkins (1988b) show that suffering is associated with a culturally profound sense of tragedy in Latin American cultures.

Different cultural traditions of suffering vary according to the salience of the "vocabulary of emotion" (Geertz, 1959), that is, whether notions of suffering are elaborated or unelaborated; expressed in secular or religious idioms; culturally valued or disvalued; relevant to the individual self or to broader social and historical contexts. While some cultures have no specific word for depression per se (Marsella, 1980), absence of a word or concept for an emotion does not preclude its presence. For example, some emotions may *elude* culture or be so deeply unconscious that they are not easily conceived or known (Obeyesekere, 1985). The cultural elaboration of depression may influence standards of individual social functioning in the face of suffering, where some may experience relatively higher levels of suffering and still perform occupational or interpersonal roles.

In the absence of a cultural concept of depression, depressive states can be studied as a feature of local forms of suffering. Indeed, some authors have documented a fundamental and pervasive "ethos of suffering" that permeates nearly every aspect of world view. "In highland Ecuador, *pena* refers to a state of mind characterized by a mixture of sadness and anxiety as well as to an illness state resembling depression . . . the ideology in which it is embedded serves to interpret a bodily problem at the same time as it reflects a more global attitude toward life . . . When misfortune abounds in the Sierra of Ecuador, life becomes a litany of *penas*, or sorrows" (Tousignant, 1984, p. 381). The ideology of *pena*, as with other Latin American attitudes toward suffering, cannot correctly be interpreted as a fatalistic resignation or submission; rather, it represents a cultural tradition of the recognition and existential working through of oppressive life circumstances.

From his ethnographic analysis of depressive moods in Sri Lanka, Obeyesekere (1985) elaborated an analytic conception of "the work of culture" to explain "the process whereby painful motives and affects such as those occurring in depression are transformed into publicly accepted sets of meanings and symbols" (Obeyesekere, 1985, p. 147). The cultural perception of chronic and pervasive suffering is expectable for any typical Buddhist. That one recognizes and accepts the inevitable condition of suffering is the first step toward the spiritual abandonment of suffering. Although suffering occupies a prominent part of life experience, it is nonetheless expected that a lay person take pleasure in everyday life. Suffering is, then, not an all-encompassing aspect of life in the sense of an ethos. Even so, Buddhist laymen may "generalize their despair from the self to

the world at large and give it Buddhist meaning and significance" (Obeyesekere, 1985, p. 140).

The foregoing examples from Latin America and Sri Lanka provide a sharp contrast with an Anglo-American ethos concerning suffering. In the latter context, suffering is not an expectable or acceptable state of affairs. Rather, it is something to overcome through personal striving, volition, and the "pursuit of happiness." A strong contrast in willingness to endure suffering was observed by Jenkins (1988a), in her comparisons of Mexican-descent and Caucasion American families who were living with a family member afflicted with schizophrenic illness. Mexican families displayed more willingness to endure suffering associated with the problem and expressed sadness more frequently and profoundly than Caucasion Americans who more commonly voiced anger and frustration (Jenkins et al., 1986; Karno et al., 1987).

Empirical investigations of indigenous conceptions of depression—as symptom, mood, or syndrome—have been rare. A notable exception is the study by Manson, Shore, and Bloom (1985) of depression among the Hopi of the Southwestern United States. The authors documented five discrete depressive conditions recognized by the Hopi: worry sickness, unhappiness, heartbroken, drunken-like craziness (with or without alcohol), and disappointment-pouting. "Each of these categories of illness is associated with a cluster of cognitive, affective, and behavioral states" (p. 337). However, for the Hopi symptoms which would be subsumed under the single psychiatric diagnostic category of depression are parsed out among different illnesses, each with its characteristic etiology and treatment. The importance of examining the clinical relevance of such cultural differences in categories of illnesses has yet to be appreciated (Edgerton, 1966; Jenkins, 1988; Marsella, 1980; White, 1982).

SOMATIZATION AND DEPRESSION

Where standard criteria and diagnostic interviews of clinical depression (ICD-9 and DSM-III) are systematically used together, the prevalence rates of depression are found to vary greatly across cultures. For example, findings range from 4.6 to 6.5% in the North American Epidemiological Catchment Area studies (Myers et al., 1984; Robins et al., 1984) to .15 to 3.3% in various studies in India (Rao, 1973). Among the highest rates in the world are those reported for Africa: 14.3% for men and 22.6% for women in Orley and Wing's (1979) Uganda research. But these rates also disclose a particularly salient cross-cultural similarity: Most cases of depression world-wide are experienced and expressed in bodily terms of aching backs, headaches, constipation, fatigue and a wide assortment of other somatic symptoms that lead patients to regard this condition as a physical problem for which they seek out primary care assistance from general practitioners (be they traditional or cosmopolitan). Only in the contemporary West is depres-

sion articulated principally as an intrapsychic experience (e.g., "I feel blue"), and even in the West most cases of depression are still lived and coped with as physical conditions (e.g., "my back aches"). The term applied to this phenomenon is *somatisation:* the expression of interpersonal and personal distress—e.g., frustration, despair, major depressive disorder—in an idiom of bodily complaints (Kleinman, 1986, 1988a). Kirmayer (1985) shows that whether somatization is a sociolinguistic or psychophysiological process, or both, remains unclear. The practical significance of somatization for cross-cultural studies of depression is that the models of depression based on studies of inpatients and outpatients in Western psychiatric settings tend to emphasize a picture of depression that is not the main one in non-Western societies (where the vast majority of the world's population and most of the depressed live). In many societies and subcultures, rules of politeness, absence of psychological linguistic terms, expression of emotion in nonverbal modes or in formal aesthetic forms such as poetry, and understanding of depression as a bodily experience lead to symptom pictures that may include little or no psychologically minded expression of dysphoria.

For this reason, depression may not be diagnosed, and DSM-III and ICD-9 categories, if used in the strict sense without an appreciation for subtlety and metaphor, may lack validity in non-Western settings or among certain ethnic populations. The forms of somatization show local cultural patterns, with neurasthenic patterns of complain common in East and South Asia and becoming popular again in the West under the rubric of chronic fatigue syndrome. Heart distress in Iran (Good, 1977), dizziness in China (Kleinman, 1986; Ots, 1990), gastrointestinal complaints among Cambodian and Vietnamese refugees in North America, physical sensations of the loss of soul or vital essence in a number of societies (Shweder, 1985), are examples of local illness idioms, final common pathways that express distress and disorder of many types, including depression (see Carr & Vitaliano, 1985). Somatization in the non-Western world, moreover, is not infrequently associated with parasitic infections, anemia owing to malnutrition, and other intercurrent physiological pathologies so that the bodily idiom of distress has a ready-made physiological basis, and one that also contributes to the onset of depression. Indeed, this is also a significant problem for diagnosis (Weiss & Kleinman, 1987), inasmuch as the symptoms of many medical disorders (e.g., anorexia, sleep disturbance, reduced energy, motor retardation) overlap with the vegetative complaints of depression, rendering diagnosis uncertain.

Somatization may also shape the course and outcome of depressive disorder. Where somatization rates are highest, guilt, low self-esteem and suicide tend to be less frequent (see Kleinman's 1988a review of this issue, pp. 42–45). On the other hand, somatization of major depressive disorder has routinely been found to delay effective treatment for depressive disorders and to contribute

to minimal utilization of outpatient and in-patient services (Katon, Kleinman, & Rosen, 1982). Anecdotal reports from clinicians suggest that somatization of depression may "protect" depressed patients from morbid preoccupation with emotional states and thus reduces the likelihood of depression becoming a way of life. To the best of our knowledge this potentially significant proposition has never been investigated. We turn our attention now to cross-cultural examination of social factors and the onset of depression. Most prominent among these are gender, social class, family relations, refugee/migrant status, and social change.

GENDER AND DEPRESSION

An overwhelming number of Western studies of depressive disorder report a significantly higher rate of depression among women than men (Blazer et al., 1985; Craig & Van Natta, 1979; Howell & Bayes, 1981; Redloff, 1985; Weissman & Myers, 1978). In a critical review of these studies, Weissman and Klerman (1981) conclude that socially inculcated gender differences in susceptibility to depression are real, that is, not based on endocrinological or genetic factors, differences in helpseeking or affective expression, or methodological artifact. For Western societies, they cite the often-quoted evidence showing greater depression among married females (vs. married males) as illustrative of the conflicts generated by the traditional female role (1981:184). The classic study of Broverman et al. (1970) documenting a strong gender differentiation in clinicians' mental health ideals has frequently been cited as evidence of the inherent conflicts posed by sex-role stereotypes in the United States (Broverman et al., 1970, p. 322). For example, healthy women are said to differ from healthy men by being more submissive, less independent, more emotional, and so forth.

Recent epidemiological evidence from the multi-site NIMH Epidemiological Catchment Area (ECA) studies confirms gender differences in the prevalence of affective disorders within the United States. From the cities of Baltimore, New Haven, and St. Louis, Robins and associates (1984) reported disorders that most clearly predominated in men were antisocial personality and alcohol abuse. Disorders that most clearly predominated in women were depressive episodes and phobias. This finding was true of all three East Coast ECA sites.

Further evidence of female psychiatric vulnerability comes from the work of Brown and Harris (1978), who found that depression was extremely common among London working class women. In addition, they identified a set of specific vulnerability factors characteristic of the life circumstances of depressed women. These include lack of employment outside the home; absence of an intimate or confiding relationship with a husband/boyfriend; three or more small children in the home; and loss of mother prior to age eleven. Howell and Bayes (1981)

formulate a similar set of risk factors, including lack of outside employment, the presence of young children, being employed in addition to household and child-care responsibilities (resulting in fatigue), family moves that follow the husband's employment and result in her own unemployment and/or social isolation. Indeed, "because of the particular constellation of environmental circumstances that rather universally characterizes married women in this culture, we are often to some extent diagnosing a *situation* rather than a *person* when we diagnose a woman as depressed" (Howell, 1981, pp. 154–155, italics in original).

Weissman and Klerman (1981) report that "The evidence in support of these [gender] differential rates is best established in Western industrial societies. Further studies in non-Western countries . . . are necessary before any conclusions can be drawn as to the universality of this differential rate" (p. 184). Although much more research is needed to map out cultural dimensions of the role of gender in predisposing individuals to depression, these authors appear to have been unaware of a small but suggestive anthropological literature from which hypotheses can be drawn.

For Africa, the most important early work was conducted by M. J. Field. Based on her study of Ghanaians seeking help at healing shrines, she reported that "depression is the commonest mental illness of Akan rural women" (1960, p. 149). Women who have recourse to the healing shrines tend to be of an age at which they should be reaping the benefits and social prestige customarily accorded to senior wives, but in many cases their positions have been undermined by their husbands' introduction of younger wives into the household. A common presenting complaint of these women is self-accusation of witchcraft. Among the Akan, witchcraft is a detested and highly stigmatized behavior; thus self-accusation indicates extremely low levels of self-esteem and self-worth.

Abbott and Klein (1979) also document depression as more common among rural Kikuyu women than men in Kenya, linking it with women's low status and concomitant powerlessness. In this culture, residence is patrilocal, and land is predominantly owned and controlled by the patrilineage. "Cultural beliefs and values regarding women generally devalue them, characterizing them as less intelligent than men, as rightly under the domination of men, and as belonging only to the home, the domestic space. Women are to defer to men" (1979, p. 181). In addition, two thirds of the men have left the community to seek wage labor in cities and towns, leaving women with the burden of horticultural labor and family responsibility (1979, p. 164). Abbott and Klein find that the least modernized women are at the greatest risk for depression, seeming to belie the common notion that modern urban life is more conducive to mental disorder than traditional rural life. However, we would suggest that in a region so much under the hegemonic sway of wage labor economy that two thirds of the men are absent, the self-definition of women may have been sociohistorically recast as "backward," hence reinforcing their subordinate status.

More recently, Mitchell and Abbott (1987) reported on the patterning of symptoms of depression and anxiety among Kikuyu secondary school students. The authors found significant gender differences in the responses revealing that females reported more depressive symptoms than males. While the extent of the gender differences in depression was not as great as in the earlier study by Abbott and Klein (1979), they are nonetheless consistent in showing a greater female preponderance of depression. This finding was also recently reported in Kenya by Ndetei and Vadher (1982). The observation that depression is an extremely common disorder among African women has been supported by Orley and Wing (1979), who found higher rates among Ugandan female villagers than among working class women in London. Orley and Wing documented depressive disorder among 14.3% of male Ugandan villages and 22.6% of female villagers.

Ullrich (1987) observed depression to be extremely common among Havik Brahmin women in a south Indian village. Ullrich argues that the traditional cultural ideal of women predisposes them to depression. Indeed, Beck's triad of negative self-image, negative interpretation of life events, and negative view of the future is regarded as the cultural ideal for older women. Additional factors that may lead to depression among women in this setting include early marriage age (an associated loss of contact with close kin), poor marital relationships, and the perception of helplessness. With cultural changes and an increase in marriage age, educational level, and decision-making, however, it now appears that this cultural bias against women is no longer fully sanctioned in this contemporary Indian village.

A striking age-related finding in the study by Karno and colleagues (1987) identifies the group most vulnerable to depression as young (18–39 years-of-age) non-Hispanic White women: over 15% of this subgroup had suffered major depression. Such age-specific vulnerabilities to depression have been noted elsewhere (Hirshfeld & Cross, 1982). These younger age cohort of Caucasian American women in the ECA study suffer disproportionately from major depression relative to men in either ethnic group or women of Mexican-descent. These findings are particularly alarming, and as noted by the authors, require further explication. Such results sound a cautionary note against simplistic reasoning concerning presumed cumulative effects of ethnicity, socioeconomic status, and gender in the absence of sociodemographic data on age. The importance of age-specific data is further borne out by Karno and colleagues' (1987) findings that dysthymia was most prevalent (9.4%) among older women (+40 years of age) of Mexican descent. Although the Puerto-Rican study did not provide age-specific data, dysthymia was also noted to be highly prevalent among women (7.6%) relative to men (1.6%) (Canino et al., in press-b).

These age-related findings also raise the question of the relationship of traditional female roles and vulnerability to depression. Prudo, Harris, and Brown

(1984) found that the types of severe life events associated with depression varied with the degree of integration into traditional society. As among African women (Abbott & Klein, 1979; Field, 1960), Hispanic women have been identified as a population at high risk for the development of depressive disorders (Mendes de Leon, 1988; Richman, 1987; Torres-Matrullo, 1982; Vega et al., 1984; Zavalla, 1984). In the United States, this group has been considered particularly vulnerable by virtue of gender and ethnic minority status, and often, lower socioeconomic status as well (Mirande & Enriquez, 1979; Zavalla, 1984). From Los Angeles, a cross-cultural component of the Epidemiological Catchment Area survey (Karno et al., 1987) was designed to include Mexican-descent populations. Major depressive episodes showed:

> a surprising ethnicity effect among women, with non-Hispanic white women under 40 years of age showing 2.5 times the rate of Mexican-American women. These differences disappear in those over the age of 40. A strong trend is present for greater prevalence of total affective disorders on the part of young non-Hispanic white women compared with young Mexican-American women. Dysthymia shows a trend toward greater prevalence among Mexican women over 40 compared with their non-Hispanic white counterparts. (p. 699)

Recent lifetime prevalence data from epidemiological studies utilizing the Diagnostic Interview Schedule (DIS) confirm a gender vulnerability (Canino et al., in press-b; Karno et al., 1987). Among a Puerto Rican sample, Canino et al. (in press-b) found significantly higher depression and dysthymia among women. Gonzales (1978) found that Puerto Rican women who had been diagnosed as neurotic or depressive and were receiving treatment had sex-role orientations significantly more traditional than did comparison (normal healthy) housewives and students. Torres-Matrullo (1982) found a high incidence of symptoms of dependence among nonacculturated mainland Puerto Rican women. "Feelings of inferiority, low-self-esteem, psychosomatic complaints, and premature marriages and parenthood among Hispanic women have been regarded as resulting from the traditional female role" (Canino, 1982, p. 123). However, empirical research is necessary for a more sophisticated understanding of gender roles in Hispanic culture, since characterizations of women in the current literature are overly simplistic:

> It is questionable whether most functional Hispanic traditional women are as subjugated, passive, and dependent on the male as the literature depicts them to be. But the question still remains as to how can we explain the higher incidence of psychopathology found among traditional Hispanic women. Is it that the role per se induces psychopathology? Or is it that dysfunction occurs more often when the woman is in a societal and family context where the traditional role is not valued, but on the contrary, is maladaptive and conflictive? (Canino, 1982, p. 124)

In light of the foregoing cross-cultural studies, we can advance the hypothesis that epidemiological studies in the Third World will reveal a disparity between female and male rates of depression broadly similar to that documented in Western societies. This hypothesis is lent credence by the nearly universal structural subordination of women cross-culturally (Collier, 1987; Farnham, 1987; Lamphere, 1987; Rosaldo & Lamphere, 1974; Sanday, 1981). Nonetheless, overall rates are likely to vary for women relative to local factors such as child socialization practices, variations in control over resources, marriage patterns, and cultural ideology and value orientations surrounding gender relations. Moreover, there are exceptions. In one epidemiological survey. Carstairs and Kapur (1976) found a higher rate of depression among men than women in a rural region of southwestern India. However, in that matrilineal society there is considerable social dislocation due to newly legislated patrilineal inheritance patterns.

SOCIOECONOMIC STATUS AND DEPRESSION

Hirshfeld and Cross (1982) recently summarized the relationship of social class to depressive disorders in Western settings: "Whether defined by occupational, income, or educational level or a combination of these, there is strong evidence that rates of depressive symptoms are significantly higher in persons of lower SES than in persons of higher social class" (p. 39). Indeed, this association has been similarly reported by numerous investigators (e.g., Craig & Van Natta, 1979; Radioff, 1985; Weissman & Boyd, 1983). However, rates of unipolar depressive disorder have also been found to be exceptionally high among upper SES professional women (Welner, Marten, & Wochnick, 1977). Reviewing lifetime prevalence of depression in a community survey, Weissman & Myers (1978) similarly reported a vulnerability to depression among the upper social classes.

Studies of general psychiatric disability and unemployment have typically shown a strong relationship between economic conditions and admissions to treatment. Brenner (1973) conducted a survey of psychiatric hospitalizations in the United States between 1914 and 1967 to show that economic downturns were associated with increased rates of hospitalization. In an extensive review of research on schizophrenia and economic conditions, Warner (1985) cites evidence of the higher prevalence of schizophrenia found in lower social classes, except during times of full employment. He noted that outcomes, such as the degree of impairment in social functioning, are linked to the type of economic structures within social groups. During periods of unemployment in wage labor economies, for example, recovery is poor relative to patient outcomes within agrarian peasant societies. In light of current epidemiological data, similar hypotheses could also be advanced for depressive disorders.

As noted before, in London, England, Brown and Harris (1978) found that working class women had a rate of depression four times higher than middle-class women. Working class women were likely to suffer a depressive episode in the year prior to research contact if they had certain vulnerability factors (e.g., lack of a close confiding relationship with a husband/boyfriend; unemployment) and had experienced a severe life event (e.g., death in the family). Findings such as these raise the obvious question of whether qualitatively different life conditions may engender vulnerability to depressive disorders, and thereby account for the association between SES and depression.

Brown and Harris (1978) lay the groundwork for empirical investigation of this issue by elaborating research methods to document life events and life difficulties. They begin with the caveat that there is ". . . nothing to suggest there is any difference in the appraisal of adversity in the differing social classes in Camberwell . . . working-class women simply have more" (p. 191). (Similar observations about the cumulative and "objective" effects of oppressive life circumstances among the poor have been reported by other investigators [Hirschfeld & Cross 1982]). In addition, because their material conditions are more tenuous than their middle-class counterparts, they suffer more in response to loss or disappointment. Brown and Harris pinpoint the subgroup of lower SES women with children living at home as experiencing the greatest number of *severe* life events. Examples of such events include learning that a husband has cancer, losing a job at short notice, son killed while at play, evicted by landlord, being forced to have an unwanted abortion because of poor housing conditions, overdose taken by schoolage daughter. For chronic depressive conditions, the higher rates of depression for working class women hold across all life stages, and are not restricted to those with children living at home.

This work suggests that attention to adverse life events may contribute a valuable element of specificity to broad-based findings about social class and vulnerability to depression. Studies which have begun to follow this lead include a comparison of depressed and normal controls in Kenya that found significantly more life events among depressed patients in the 12 months preceding onset (Vahder & Nedetei, 1981). In an independent line of research Paykel (1978) has also documented the precipitation of clinical depression by stressful life events. Brown and his colleagues have continued to increase the specificity of the relation between particular types of severe life events and characteristics of women at risk (Brown, Bifulco, & Harris, 1987; for a methodological critique of Brown's earlier work see Tennant & Bebbington, 1978).

Consistent with the approach adopted by meaning-centered medical anthropology (Good & Good, 1982) is the finding that the most important aspect of life events is the meaning attributed to specific and cumulatively distressing life circumstances. Rather than the impact of change per se being deleterious to one's mental health, it is the personally incorporated cultural meanings of those events that appears to be of crucial importance (Brown, 1974; Brown & Harris, 1978;

Day et al., 1987). Moreover, social supports have routinely been shown to be less available and more fragile for lower socioeconomic persons. Inasmuch as this feature of the social environment also predicts for depressive onset, comparative studies of the meaning of supports would seem to be another avenue for future cross-cultural research. From the anthropological standpoint, stressors and supports are systematically bound together within local social systems. These systems may protect individuals (and categories of individuals) from major social pressures or may render them particularly vulnerable to forces of deprivation, oppression, or loss (Kleinman, (1986), forces which can create local vicious cycles of demoralization and defeat. The anthropological perspective calls for a different methodology for measuring stress and support, one that takes into account the ethnographic description of the changing social contexts within which events are perceived, experienced, and managed.

Relatively scant attention, on the whole, has been allotted to the question of socioeconomic status and depression cross-culturally. This is in part due to the difficulty of obtaining valid indicators of social stratification and class variation, on the one hand, and the paucity of cross-cultural studies on depression, on the other. However, these studies consistently report that the least educated have higher depression scores (e.g., Abbott & Klein, 1979; Vega et al., 1984; Zavalla, 1984). Moreover, the other major component of social class, employment, is also linked to depressive illness (Dressler, 1986; Ndetei & Vadher, 1982). Dressler and Badger (1986) found that among Blacks in the southern United States unemployment was significantly related to higher depressive symptomatology, independent of other demographic factors or stressful life circumstances. These findings support the general conclusion that unemployment engenders a substantial risk for the development of depression.

DEPRESSION AMONG REFUGEES AND IMMIGRANTS

Recently, there has been a proliferation of studies of the relation between political exile and depressive disorders. Depressive illness is apparently quite common among Southeast Asian refugees (Beiser, 1985; DeLay & Faust, 1987). In a survey of 97 Hmong adult refugees in the U.S., Westermeyer (1988) found a very high rate of psychiatric and social disorder that included major depressive illness. A group that was found to be particularly vulnerable to depression was unmarried Laotian and Vietnamese refugees, who showed high levels of depression in the 1–12 months following their arrival. Other investigators have also found depression to be extremely common among Vietnamese refugees in primary clinic settings.

In an Indochinese clinic population in the United States, many of the patients had concurrent diagnoses of major affective disorders, posttraumatic stress disorder, and medical and social disabilities resultant from a history of trauma and

torture (Mollica, Wyshak, & Lavelle, 1987, p. 1567). The most vulnerable subgroup identified by these investigators was unmarried women. These women, typically the victims of rape and torture in the natal countries, suffered the most severe psychiatric and social impairment.

A protective factor identified for Indochinese refugees in the U.S. is living arrangements with families of similar cultural background: refugees in these settings were found to be significantly less depressed and had better school performance than those who lived in foster homes with Caucasian families or in group homes. Beiser (1988) investigated the issue of whether resettlement in Canada is associated with an increased risk for depression among Southeast Asian refugees, and found that better mental health was enjoyed by refugees the longer they remained in Canada. Length of time after displacement was also found to be associated with decreased symptom levels in a study of Iranian immigrants to the United States (Good, Good, & Moradi, 1985).

In Africa, the prevalence of depressive symptomatology among Namibian refugees residing in a sub-Saharan host country was quite high (Shisana & Celentano, 1985). These authors also found that social support helped to ameliorate the effects of chronic stress, as represented by the length of time in exile, but that depressive symptomatology was to be understood as directly associated with difficulties incurred by the problems posed by the stressors of adaptation and acculturation.

Vega et al. (1986) conducted a large survey of immigrant Mexican women in southern California. Using the Center for Epidemiological Studies Depression checklist (CES-D), they determined that there was an inverse association between CES-D scores and number of years in the United States. Depression has also been reported as extremely common among Mexican immigrants in Northern California, and has been linked to the difficulties associated with living conditions that include racism, unemployment, crowded and unsanitary living situations, and nondocumented legal status (Ring & Munoz, 1987).

In a study of Iranian immigrants to the United States Good, Good, and Moradi (1985) document the interplay of cultural themes, sociopolitical events, and depressive disorder. Iranians interpret and communicate depressive symptoms in relation to elements already thematized in Iranian culture: sadness and grief are essential qualities of life elaborated in Shi'ite religious culture and popular literature, insecurity and mistrust are common interpersonal themes especially with regard to interpersonal relations and marital fidelity; uncontrolled anger is a culturally marked and stigmatized sign of depression; and emotional "sensitivity" acquired through early childhood experience is a common personality self-attribution. The experience of depression consequent to political deracination is shaped by these four cultural themes.

A factor analytic study of psychiatric symptom levels assessed with the Brief Symptom Index (BSI) in a nonclinical population of Jewish Iranian women immigrants suggested the presence of a distinctly Iranian depressive syndrome,

the symptoms of which cross-cut the pre-established categories of the Western-based epidemiological instrument. Based on cross-sectional analysis, reported symptom levels peak at 2 years postmigration and decline thereafter, a time frame which the authors suggest is typical of a grieving process and indicates that the culturally elaborated grieving process remains intact for these immigrants. Among types of losses reported, including loss of wealth, home, and one's "very life," the lowest symptom levels were found among those emphasizing loss of friends. In line with their association of the grieving process with adjustment to the immigrant experience, Good, Good, and Moradi (1985, p. 413) suggest that "the ability to have and to mourn the loss of close friendships is a mark of a healthier immigrant" (see also Good & Good, 1988). However, longitudinal studies are necessary to separate adaptation processes from cohort effects.

Research is only now becoming available on depression among political refugees from Central America (Williams, 1987), especially El Salvador and Guatemala (Guarnaccia & Farias, 1988; Jenkins, 1989), and much more attention will need to be paid to this topic as these groups continue to enter the United States. In the clinical/research experience of the first author (JJ) and her Latino colleagues from a specialty Latino clinic in a Boston area hospital, depression, among other psychiatric disorders (e.g., dysthymia, panic disorders and posttraumatic stress syndromes) is very frequent, and is apparently due to the after effects of political violence and inhospital life conditions in American urban settings. While forced uprooting and difficulties of acculturation are sources of distress, political oppression and turmoil also clearly have an effect independent of migration.

DEPRESSION AND FAMILY FACTORS

While the influence of early developmental experience for subsequent onset of depression has long been presumed in psychoanalytic circles (e.g., Arieti, 1959; Robertson, 1979), empirical evidence for Western or cross-cultural examination of such theories has been lacking. In a recent review Campbell (1986, p. 47) notes the surprising paucity of research on the family and depressive disorders. Nonetheless, there have been hypotheses concerning the etiology of depression in relation to cultural variations in socialization practices and family structure. Several family contextual factors have been examined, including number of primary caretakers (for presumed minimization of child frustration), family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and patriarchal structure to rates of depression.

In a recent study by Weissman and colleagues (1984), depressive illness was found to be three times more likely among children who had parents with major depression. As noted by Campbell (1986), "the extent to which the increased depression is due to genetics versus the family environment has not been deter-

mined and requires adoption studies similar to those used in schizophrenia" (p. 48). And, as with studies of schizophrenic disorders, identification of specific family factors that are of etiological significance is problematic in depression research. A major dilemma is the difficulty of identifying factors that reliably distinguish between "disturbed" and "normal" families. For example, in a study of child rearing behavior in Swedish and Dutch samples, Arrindell et al. (1986) found family "rejection" and "emotional warmth" to be similarly present among families of depressed patients and healthy controls.

On the other hand, several investigators have found major differences in the qualitative features of family life that may lead to psychiatric vulnerability. Zavalla (1984) has documented significant differences in negative parental experiences among depressed Mexican-descent women. Mothers were reported to have been indifferent, strict, or authoritarian by 33% of her sample of depressed women (which contradicts the culturally prescribed ideal of Mexican mothers as warm, indulgent, and protective). In her sample of depressed women, 42% reported their fathers as indifferent, strict, authoritarian, and abusive. In Zavalla's thoroughgoing investigation of psychosocial and sociodemographic factors related to depression, reports of negative child-rearing experiences emerges as the most significant factor for the development of clinical depression. Parker (1983) found that a sample of depressed patients considered their parents to be aloof, controlling, and overprotective compared to controls or other illness groups.

The clinical and research experience of numerous cross-cultural investigators has led them to assign dysfunctional family dynamics an instrumental role in the genesis of disorder (e.g., Campbell, 1986; Rogler & Hollingshead, 1965; Scheper-Hughes, 1979). For ethnic minority groups, family dysfunction is complicated by acculturation pressures. Canino (1982) links these two factors, and argues that acculturation pressures among dysfunctional Puerto Rican families are more likely to compound one another in ways that are less disruptive among more high functioning families.

This line of investigation has been criticized with regard to the validity of subjective, retrospective accounts by persons who are (by selection criteria) troubled with psychiatric illness. Formidable as these difficulties are, however, the methodological dilemma posed should not result in either the dismissal or eclipse of life history materials for the role of psychocultural and family factors in the development of affective disorders. Among the methods to improve the reliability of patient reports are corroborative evidence obtained from other sources, such as family members, and school and medical records (Brown, 1981).

Marital discord has been widely acknowledged as a vulnerability factor for depression, particularly in women. Brown and Harris (1978) identified the lack of a confiding relationship with a husband or boyfriend as particularly important. Paykel et al. (1969) noted that the onset of a depressive episode is frequently

preceded by an increase in arguments with a spouse. Indeed, during an active illness episode, depressed women report a variety of interpersonal difficulties with families, including arguments and quarrels (Weissman & .Paykel, 1974). Thus gender variation in the prevalence of depressive disorder appears to be related to qualitative features of marital or family life, such as intimacy (Brown & Harris, 1978; Vega et al., 1984).

However, since the etiological relevance of family factors remains unsubstantiated, some researchers have turned their attention instead to an examination of how such features may affect the course and outcome of psychiatric disorder. This shift in emphasis began with psychosocially and cross-culturally oriented schizophrenia research. In the late 1950s, Brown and his colleagues developed a methodology for assessing particular aspects of the family emotional environment and observed how these affected the course of illness. This line of investigation, which has come to be known as "expressed emotion" (EE) research, focuses on family response to and attitudes toward a relative who had been hospitalized for an acute psychotic episode. The EE index measures criticism, hostility, and emotional overinvolvement expressed about the patient by close family members. Brown, Birley, and Wing (1972) found that high levels of criticism and overinvolvement were associated with poor prognosis, and that high EE predicted schizophrenic relapse none months subsequent to hospital discharge.

This British study was replicated among English-speaking populations in the United Kingdom (Vaughn & Leff, 1976) and the United States (Vaughn et al., 1984), and among Mexican immigrants to the United States (Karno et al., 1987). Results of the Mexican study confirmed the significance of "expressed emotion" (EE) to outcome, and that EE could be employed in a culturally meaningful way in Spanish within a distinctively different cultural context (Jenkins, Karno, & de la Selva, in press). This cross-cultural validation, however, required adaptation of the scales to culturally appropriate expressive styles and values of interpersonal relations within families.

In the English replication by Vaughn and Leff (1976), EE research was extended to a sample of "neurotic depressed" patients. The average number of critical comments for this group of relatives was the same as for schizophrenic patients, indicating that there were no illness-specific family response styles (Leff & Vaughn, 1985). However, it was discovered that depressed patients relapsed at a significantly lower threshold of criticism than the schizophrenic sample. Thus it appears that depressed patients are even more sensitive to negative affects than are their schizophrenic counterparts. A more recent study of 39 depressed patients found that negative expressed emotion on the part of spouses significantly predicted the course of illness: 59% of the patients with high EE spouses relapsed, whereas *no* patients living with low EE spouses did so (Hooley, Orley, & Teasdale, 1986). These results provide further support for those originally obtained by Vaughn and Leff (1976). EE research has been extended to

families of schizophrenic patients in India, but we are not aware of cross-cultural studies of EE among the families of depressed patients.

A much neglected area of research into psychiatric disorder and familial relationships concerns how the illness comes to affect the family (Good, Good, & Burr, 1983; Jenkins et al., 1986; Jenkins, 1988a, 1988b; Kleinman, 1980, 1988). Sartorius (1979) has estimated that over 100 million persons in the world suffer from depression and that perhaps three times that many persons are affected by their suffering. Coyne and his colleagues (1987) have summarized a wide range of literature on the role of close relationships in the etiology, course, and outcome of depression, and the negative impact of depression on close relationships:

> Interactions between depressed persons and their relatives are negative and conflictual. It seems such a familial environment would take its toll on relatives as well as on depressed persons. A depressed family member may provide a major source of stress and a loss of social support, which could trigger a disturbance in vulnerable persons. Indeed, there is evidence that spouses of depressed persons often have family histories of psychiatric disturbance and thus may be prone to affective disturbance (p. 347).

To date, there is no evidence to support a generalization of this conclusion, since the cross-cultural study of family and community response to depressive disorders is a neglected area of inquiry. Among areas that must be documented before generalizations can be made are culturally based conceptions of depression, criteria by which depression is indigenously recognized and identified, and explanatory models of depressive illness. Likewise, documentation of cultural coping responses is contingent on community resources, the structure of interpersonal social networks, and intrafamilial styles of expressed emotion.

DEPRESSION AND SOCIAL CHANGE

Tsung-Yi Lin and his colleagues in Taiwan have demonstrated that rapid urbanization, industrialization and related social changes in that society from the late 1940s to the middle 1960s were accompanied by escalating rates of depression and anxiety disorders (Lin et al., 1969). Yeh et al. (1987) found that this increase persisted and even worsened in the 1970s and '80s. Leighton and his coworkers (1963) in the celebrated Sterling County Study showed that the social breakdown of a community correlated with measured rates of mental distress, including depression and anxiety complaints. These epidemiological studies are complemented by ethnographic and historical accounts of increased hopelessness, despair and demoralization in the wake of community changes that place large numbers of persons under the severest pressures of economic disloca-

tion, unemployment, lack of resources and supports, intensified oppressive relationships and dependency (see, for example, Warner, 1985). Brenner (1981) has shown, as already noted, that economic depressions forecast increases in mental hospitalization and suicide, indirectly indicating that depressive conditions are very likely more frequent. Kleinman (1986), studying the survivors of the Great Proletarian Cultural Revolution in China, found that, among vulnerable individuals, macrosocial calamity frequently provoked depressive conditions, especially in local settings where victims were least protected by the community. All of these indicators register the relationship of depressive disorders to major social historical transformation. That these changes are most commonly not examined in clinical and epidemiological research suggests that a more fundamental large-scale social impact may be significant in the onset of depression and its recurrence than has heretofore received study.

METHODOLOGICAL PROBLEMS IN CROSS-CULTURAL RESEARCH ON DEPRESSION

Psychiatric epidemiology relies on instruments to elicit self reports of symptoms and on standardized clinical interviews, nearly all developed in Western cultural settings and with North American and European patient populations. Given the variability of depressive symptoms and disorders cross-culturally, the use of standard instruments must evoke strong methodological caution. Whereas both validity and reliability have been of great concern in Western psychiatric research, with instruments growing out of wide clinical experience, cross-cultural research has focused almost exclusively on the reliability of research methods. When instruments developed for use in the West are directly translated for use in non-Western settings, several methodological difficulties are hidden, however careful the translation. These may be summarized as five problems of cross-cultural method (see Good & Good, 1986).

   1. The Problem of Normative Uncertainty.   All psychiatric ratings are ultimately grounded in culturally specific and locally defined judgments about normal and abnormal behavior. Interpretations of individual symptoms or behaviors, of level and duration of symptoms, and of scalar values all require assumptions be made about what is abnormal for a particular culture.
   Cross-cultural and cross-group comparisons of symptom checklist data raise particular problems. For example, researchers have consistently found higher levels of psychological symptoms among Puerto Ricans than other American populations (Dohrenwend & Dohrenwend, 1969; Srole et al., 1962). Still unresolved is whether levels of psychiatric illness are actually higher among Puerto Ricans or whether this represents culturally prescribed differences in communicating symptoms. Many researchers (e.g., Haberman, 1976) have concluded

the latter, that is, that differences reflect culturally patterned variations in ways of *expressing* distress rather than actual degree of pathology. Such problems bedevil interpretations not only of cross-cultural data, but also comparisons between men and women and among ethnic groups. Researchers often elect either to compare scores derived from standard psychometric instruments administered across groups directly, assuming comparability of scores, or, alternatively, to develop norms and compare groups controlled for differences in norms.

Diagnostic judgments face similar problems. Not only is symptom (dysphoria, loss of energy, feelings of worthlessness) grounded in judgments about normality, so also are determinations of threshold and duration. The distinction between dysthymia and major depression is a case in point. The two are currently distinguished by duration and number of symptoms. To count as dysthymia an illness must be "not of sufficient severity and duration to meet criteria for a major depressive episode (although major depressive episode may be superimposed on dysthymia). Clear "cutoff points" between normal dysphoria and pathological depression or between dysthymia and major depression have never been definitively demonstrated within our own culture. Assuming that such a threshold exists in principle, there seems little empirical reason to believe that it is the same across cultures, since cultures incorporate dysphoria into normative behavior in varying ways (Good, Good & Moradi, 1985; Jenkins, 1988a, 1988b; Manson et al., 1985; Obeyesekere, 1985; Toussignant, 1984).

2. The Problem of Centricultural Bias.   Wober (1969) has labeled those research strategies that begin with a research instrument developed and validated exclusively in one culture and directly translate them into languages for use in other cultures as "centricultural." Difficulties associated with the centricultural approach can be illustrated by cross-cultural variation in the content of symptoms. For example, the Yoruba literature (Murphy, 1982) indicates that anxiety disorders are associated with three primary clusters of symptoms: worries about fertility, dreams of being bewitched, and bodily complaints (Collis, 1966; Jegede, 1978). As noted earlier, research by an Ibo psychologist indicates that a rich somatic vocabulary is typical of Nigerian psychiatric patients (Ebigbo, 1982). For instance, patients commonly complain that "things like ants keep on creeping in various part of my brain," or "it seems as if pepper were put into my head," in a manner that would be interpreted in nearly any North American patient as psychotic.

Such differences in symptoms raise two very clear difficulties for research following the centricultural approach to translating diagnostic criteria and epidemiological instruments. First, a wide range of symptoms typical of a particular culture may simply be omitted from consideration because they are not present for the development of the criteria. Second, differences in content and duration of symptoms of diagnostic significance across cultures are ignored. Simple translation of those symptoms found to result in valid diagnosis among particular

American populations does not ensure the validity of these symptoms as criteria among other cultures.

3. The Problem of Indeterminacy of Meaning.   The most typical approach to the translation of psychiatric diagnostic criteria is to locate *semantic equivalents.* Items are translated from English into a non-Western language, then back-translated into English to check for accuracy in translation, and finally administered to bilingual subjects. As Good and Good (1986) note, "Such a method assumes the existence of objective and universal referents, which may be represented by different symbolic forms in different cultures." However, most psychiatric symptoms have no such extracultural referents. Guilt, shame, and sinfulness, which could be combined as a single item on the DIS, had to be carefully distinguished for Hopi Indians (Manson et al., 1985, p. 341). Even seeming physiological symptoms, such as 'heart palpitations,' belong to extraordinarily different semantic and phenomenological domains across cultures (see Good 1977), rendering determination of equivalence of meaning extremely difficult.

4. The Problem of Narrative Context.   As we have noted, peoples express symptoms differently across cultures. However, this same point also applies across specific intracultural *contexts.* Thus, how a patient presents his or her problem in a clinical office consultation with a physician might be quite a different representation than is conveyed at home to a close relative or friend. For this reason, the sampling of patients' complaints in different contexts—at home, with primary care practitioners, with native healers, in a church healing ritual—may well give a very different picture of a patient's symptoms, accounting for disagreements in reports of such phenomena as somatization (Cheung 1982, 1984; Good & Good 1988; Jenkins 1988b; Kleinman 1986).

5. The Problem of Category Validity.   We have raised the problem of whether depressive disorders can be identified through the use of universal categories. While we have little doubt that some forms of depression are found in all populations, at issue are such questions as whether some forms of the illness, experienced primarily in psychological terms associated with strong feelings of remorse and guilt, are to be equated with that experienced primarily in sociosomatic terms (Kleinman & Good, 1985). The problems raised about norms and equivalence of meaning thus point to more fundamental questions about mapping even culturally appropriate symptoms onto universal categories. Only research that directly examines this issue can tell us whether particular categories are universal or whether seeming universality is produced as an artifact of research and clinical method.

In the limited space available we can only briefly refer to several efforts to develop or revise psychiatric research instruments for cultural validity. Mollica, Wyshak, de Marneffe, & LaVelle (1987, p. 497) developed and validated a

Cambodian, Laotian, and Vietnamese version of the Hopkins Symptom Check-list-25. This abbreviated assessment instrument provides an effective screening method for symptoms of depression and anxiety, and was found to be particularly useful in evaluating trauma victims. The Beck Depression Inventory has been validated for use in Arabic (West, 1985) although the mistake must not be made of assuming that such an instrument will be valid in all Arabic cultures.

Researchers attempting to develop a Hispanic variant of the Diagnostic Interview Schedule (DIS) were able to obtain useful results with a somewhat modified translation among Mexicans (Karno et al., 1987), but found it necessary to prepare substantially different version for Puerto Ricans (Canino et al., in press-a) due to ethnic variations in Spanish vocabulary and usage, as well as cultural norms concerning inquiries into sexual behavior. Manson and colleagues (1985) developed a Hopi translation of the DIS based on a three-stage process of eliciting culturally meaningful mental illness categories and identifying their criterial symptoms, developing a Hopi diagnostic interview, and translating relevant portions of the DIS to be combined with the indigenous categories in a new instrument. Given the cultural specificity of somatic symptomatology among Nigerians, Ebigbo (1982) found it necessary to develop a culture-specific screening scale for psychiatric assessment. Fava (1983) conducted a study to validate an Italian language version of the CES-D, and concluded that it could sensitively discriminate between depressed patients and normals. These studies, though preliminary in several instances, represent a significant methodological advance over literal translation of research instruments, by taking into account cultural differences in the experience and presentation of depressive symptomatology. Valid cross-cultural research requires that such methodological adaptations should be actively pursued. Given the current investment in translating instruments such as the DIS for cross-cultural epidemiological studies, collaboration between anthropologists, local clinicians, and epidemiologists and new standards for cross-cultural epidemiological research are urgently needed in the field.

DIRECTIONS FOR FUTURE RESEARCH

In light of the methodological discussion, we suggest that cross-cultural research on depression emphasize the relationship of depression to the local context to assure cultural validity. The examination of cultural contexts is the domain of ethnographic research. Although the specific methods of ethnography are too diverse to summarize here, in general terms, ethnography is concerned with the description of patterns of shared cultural meaning, behavior, and experience. Ethnographic methods range from observational analysis to detailed interview data and can be applied in the domains of public culture and individual or family settings. The medical ethnographer observes individuals not just in the role of patient but in that of spouse, parent, worker, neighbor, and so forth. The eth-

nographer may therefore spend many hours conducting these observations of individuals in different situations and settings. An ethnographic approach to the contextualization of variables (e.g., life events, expressed emotion, explanatory models) can be of value in examining the complexity of the social origins and consequences of depression. For example, while we have substantial evidence that "expressed emotion" is associated with the course and outcome of depression (Karno et al., 1987; Vaughn & Leff, 1976; Vaughn et al., 1984), we know relatively little about how or why this factor mediates illness careers. Ethnographic observational data of everyday family life may contribute toward the specification of these relationships in culturally meaningful terms (Jenkins, Karno, & de la Selva, in press).

Another advantage of ethnographic methods is their ability to establish the validity of analytic categories where what is taken for granted in the social life of subjects—cultural assumptions and ground rules—challenges the conceptual underpinnings of those categories. The difficulty with these approaches is that close reading of cultured meaning and behavior precludes extensive surveys, random sampling, and large sample sizes, all of which are necessary for reliable testing of hypotheses. The complementarity of these approaches is fundamental, and no researcher attempting cross-cultural studies in mental health should exclude an ethnographic component of research.

The foregoing discussion also suggests that much more attention must be given to the intricacies of personal relations in cultural context. As we have seen, the work of Brown and his colleagues has demonstrated the importance of social response— "expressed emotion"—to schizophrenic and depressive outcomes. A series of interrelated hypotheses suggested by this work might be as follows. If someone is considered (by self *and* others) as worthless, lacking in energy, excessively worrying, it may be particularly debilitating, for "if one takes this behavior personally or otherwise becomes emotionally overinvolved, the burden . . . can be aggravated" (Coyne et al., 1987, p. 351). If, however, depressive symptoms and social response are not influenced by cultural frameworks of personal blame or fault, then outcome is likely to be more favorable. Again, if the illness behavior is somatized and the illness conception does not incorporate personality attributions about either the afflicted or affected, course of illness and social response of kin groups may be less debilitating or distressing (Kleinman, Good, & Guarnaccia, 1986). Testing these hypotheses requires careful documentation of cultural meanings as they are brought into play in particular interactive settings.

Cross-cultural variations in notions of the self may also be associated with the course of depressive disorders (Marsella, 1980). Major differences in sociocentric versus egocentric orientations to the self, accompanied by respective kingroup or individualistic values, may temper the process of self-identification with dysphoric affects and bodily states. On the one hand, it could be hypothesized that a more sociocentric sense of self would provide protection from a near

complete ego-identification with depressive states. On the other hand, it could also be that a more relationally identified sense of self could predispose to greater susceptibility to others' troubles and difficulties. Such hypotheses have been advanced for women's mental health status, but as of yet have not been adequately tested. More specific understandings of vulnerability of women to stress and depressive illness are required. As noted earlier, future research that seeks to examine the interactive processes and contextual specificities of depressive disorder can be productively pursued through ethnographic techniques.

In conclusion, we agree with Marsella et al. (1985) "that cultural factors constitute an important context for all aspects of depressive experience and disorder and they must be considered if an accurate understanding of depression is to be achieved" (p. 300). Likewise, we concur with Sartorius (1986), who calls for a more central role for comparative research in determining the nature of depression: "Properly conducted cross-cultural research can yield results which can help to resolve the conundrum of depression and respond to the challenge which depression poses to the society, to public health authorities, and to the individuals who suffer from it" (p. 6). Such research is critical to resolving the dual shortcomings in current literature on this subject, in which depression is not granted an ontological status on a par with physical diseases by anthropologists, and is stripped of personal and cultural meanings by biological psychiatrists.

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