

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 egocentricity 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 “sociocentric” (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 exemplary 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 Caucasian 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 oversimplify 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 Muslims. 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 Caucasian 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 Caucasian 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 *somatization*: 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)