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 Checklist-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 Diagnotic 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 kin-group 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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