

# A Review of Ethnopsychiatric Studies of Depression

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## THE CONFLUENCE OF PSYCHIATRY AND ANTHROPOLOGY

One of the common goals in medical anthropology is to elucidate the significance of culture in determining health and thus clarify the complex biopsychosocial model to provide better, more appropriate care (1). Prominent among environmental influences is the society in which a person develops; and it is his position in this constellation of people, with their shared ethos and world view, which molds experience, cognition, and affect (2). Cultural meanings, norms, and power arrangements shape illness to a great degree by defining the sick role and consequent illness behaviors. Medical anthropology, as a discipline, has among its concerns the cultural content of health and illness behaviors; it includes studies of how social experiences define sickness and shape ideas of disease recognition and therapy (3). Both physician and patient offer, either unconsciously or consciously, explanatory models of disease and expectations of the health care system which form a continuum ranging from full agreement to mutual disregard (4). These observations spring from a cursory glance at even a single society and accumulate greater power when comparative cultural studies are involved, as is the case in cross-cultural psychiatry.

The union of anthropology and psychiatry seems an old and natural one (5). Both anthropologist and psychiatrist hold an interest in the unusual, often couched in terms of a search for human universal truths (5). This is evidenced by the many studies done in exotic places or on personalities seen as odd (6). The definition of odd involves the social labeling of deviance and thus varies among cultures. This is the basis for Benedict's claim that what is abnormal in one context may not be so in another (7). Each field includes investigations of how societal factors influence the personality of the individual and, in turn, how groups of individuals develop institutions (5). The coupling of anthropology and psychiatry is not without difficulties, but the confluence of their methodologies and theories promises a clearer understanding of man in his biopsychosocial

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world. Thus, the attempts of anthropology to view man's ideas and behavior within the context of culture and society, combined with the attention psychiatry gives the distinction between normal and abnormal behaviors in individuals, provides a field rich in promise and problem.

Psychiatry, derived etymologically as the science of the soul (the Greek: *psyche*, meaning the soul and *iatreia*, meaning to heal [9]), is especially susceptible to difficulties involving conceptualization and belief. These difficulties are compounded when cultural discrepancies render unintelligible the overly literal "translation" of idioms and belief systems. The recent literature on depressive nosology illustrates these concerns. Depression "is likely the most common psychiatric disease in the world" (10). There exists serious debate regarding how and, indeed, whether it is manifested in countries of various descriptions: "'Western' and 'non-Western'; 'underdeveloped,' 'developing,' and 'industrialized'; 'primitive' and 'civilized' " (11). The diagnosis of depression presents even Western-trained psychiatrists treating Western patients with difficulties (10,12,13). Given the widespread occurrence of depression, a review of the adequacy of cross-cultural attempts at diagnosis of the illness seems appropriate.

#### THE NEED FOR CULTURALLY RELEVANT CRITERIA

The epidemiology of depression is currently receiving considerable attention since quantifying the distribution of any disorder is a major step toward enhancing care. A cogent clinical description with a consistent definition by which one can label cases of the illness with reliability, sensitivity, specificity, and validity is required before one can measure the prevalence of an illness (15). This presents a serious problem for the diagnosis of depression (16). There are those who would define it by the presence of an array of affective symptoms, and others who would use biochemical or hereditary constructs showing etiological considerations (17). Most commonly, clinicians use symptom profiles or syndromes to invoke a positive diagnosis when certain inclusion criteria are met and exclusion symptoms are absent. This confusion is heightened by the emergence of ever more sophisticated psychiatric taxonomies (17).

Is depression a mood, a symptom, or a syndrome? Does it have static features by which it can be identified? Before studies can be compared across cultures, the definition of depression within each culture must be agreed upon by the investigators. Marsella, in his article on structuring cross-cultural studies, suggests an "*emic* determination of disorder categories" (*italics added, ed.*) (14). *Emic* studies are based on the idiomatic phenomena meaningful in the index culture as the first stage in improving understanding of depression. By this relativistic method, investigators take into account the ways in which depression is elaborated in various cultures. Rather than deny the existence of depression in non-Western or undeveloped areas because the affect may not fit typical Western descriptions, researchers look for other manners of distress presenta-

tion (18). The salient features of the depressive syndrome as seen in Western cultures may not be applicable to people of other cultures. Olatawura states that an "exploration of the patient's on-going life-style" could clarify the meanings each patient's symptoms have for him (19). Under close examination, psychiatric theory appears ethnocentric as it has developed in Western societies (4,7,11). It is not certain that diagnoses within Western cultures are reliable, sensitive, specific, or valid when applied across cultural boundaries (20). Criteria must be refined by studying those people whose characteristic reactions are denied validity in their own society" before normality or abnormality can be considered in cultural context (7). Margaret Mead wrote, "no labels are suitable for all cultures" (21). Surely this is true for categories of disorder as well. As Sartorius et al. observed: "Research methods developed in one cultural setting often prove inadequate or misleading in another," and diagnoses must be "adapted to conditions in different countries" with "changes in training, approaches and practices" for the apt extension of Western psychiatry (22).

The way in which an individual experiences a disorder is the crux of diagnostic reality. His experience is shaped to a large degree by his culture with its implicit theories of illness. Inferred from such realities and explanatory models are ideas of etiology and remedy (23). People of many non-Western societies are seen to experience depression more somatically than do their Western counterparts (4,5,11,16,19,23) thereby complicating diagnosis. Since many cases of depression are missed in the United States due to "masked" presentation, i.e., when presentation is of somatic rather than psychological complaints (10), it is hardly surprising that researchers using Western definitions in foreign countries consider the prevalence of depression to be low or non-existent if people in those areas are culturally conditioned to somatize. The tendency to psychologize the self is very much a Western one; the terms "mental health" and "mental illness" reflect the mind body (23-25). This may be seen in the health-seeking behaviors of Westerners, in terms of which facilities and specialists they seek out when feeling ill.

Most Asian and African models of illness invoke "concepts of health which view man as a microcosm" within a larger setting, with disorder (physical or mental) indicating dysfunction in this relationship (24). This accounts for the underutilization of mental health resources by people of cultures viewing health in this way, instead resorting to therapeutic methods which address the whole body (23). The paucity of psychological explanations of depression in different countries is reflected in the underdeveloped vocabulary for feelings and emotional states (25-27) so commonly elaborated in Germanic and Romance languages. The cultural significance of various psychological concepts is revealed by studies of semantics and idioms of different languages and cultures (25,26,28). It seems that the Western Cartesian legacy grants an existential, psychologically imbued experience of depression whereas many non-Western philosophies allow a more holistic one. This difference is of utmost importance when constructing emic categories of disorder.

## TOWARD CULTURALLY RELEVANT CRITERIA

Marsella lists three further steps to complete the "systemic assessment of depression across cultures" (14). Following the determination of culturally relevant categories of disorder, baselines for the frequencies, intensities, and durations of problems should be studied to establish the pertinent cultural norms. Indices of disorder could thus be determined for individual cultures, leading to a psychiatric ethnography with objective parameters regarding problem patterns. Methodologies which quantitatively factor and cluster variables to allow secure cross-cultural comparisons are Marsella's primary goal. Marsella's suggestions for studies across cultures are based on his belief that present research methods are not standardized and that concepts of depression are inadequate. Comparative studies require consistent methodologies; the anthropologic task encountered by investigators of depression across cultures requires the determination of culturally relevant definitions. The benefit of directly comparable data from established normative baselines and multivariable data processing is clear. Directly comparable cross-cultural data about depression using various cultural definitions may be reliable, but without emic definitions, any baseline norms, factor analysis, and cross-cultural comparisons hold no valid meaning. Should distinct syndrome categories coincide across cultures, certain symptoms when set apart from their cultural features may have diagnostic, prognostic and treatment ramifications.

## A CRITIQUE OF SEVERAL RECENT STUDIES

If one believes that there is good reason to investigate depression across cultures, the problem of constructing emic categories remains. What follows is a critical review of recent literature concerning depression which incorporates Marsella's suggestions.

Depression in Afghanistan has been addressed by Waziri (27); he writes that depressive disorder is "attributable to basic illness and cultural variables" manifested as "dysphoria, negative disturbances, feelings of self-blame, guilt and hopelessness" with diurnal mood variation. Chosen as diagnostic criteria for depression were dysphoric mood, sleep disturbance, and the loss of appetite or libido. Waziri noted that the languages of the region have no simple words to "convey psychic depression"; people typically described their sadness "as if a strong, hard hand were squeezing (their) hearts." This feeling was differentiated from grief—patients denied it was akin to how one felt at the loss of a loved one. Somatic complaints were quite common.

Waziri goes on to state that "given stringent diagnostic criteria for depression in one culture, it is possible to describe and compare the symptomatology of depression in another," and that his study shows that "core symptoms of depression are quite consistent cross-culturally." Exception may be taken to these statements given that the diagnosis of depression within even a specific

culture is not clear cut (13,16,29). When one searches in another culture for depression as evidenced by certain symptoms, one necessarily misses cases which have different modes of presentation, yet which can be seen as depression from alternate perspectives. In a reformulation of the Sapir-Whorf hypothesis with its Kantian roots (30), the Afghan's lack of words to describe certain emotional conditions suggests a concept of depression unlike Western ones. Waziri applies criteria derived in the West, with sensitivity to Western notions of normality, health-seeking processes, historical influences, and other clinical realities without regard for the cultural uniqueness of Afghanistan. He fails to build a category of emic relevance for depression and thus fails to establish normative indices of a culturally defined depressive syndrome. His objectivity is limited by the application of Western diagnostic criteria to non-Western populations.

In a study of depressive illness in India, Nandi et al. (31) conclude that there are no significant differences in phenomenology or prevalence between rural and urban samples, nor between their data and data from Western samples. They claim that East-West differences have been too hastily assumed even when significant statistical discrepancies have been found, since "characteristics of a sample can hardly be designated as the characteristics of the people of a country or a group of countries." They are hesitant to hold up an illusory "statistical fiction" (2) in place of a real person requiring psychiatric care. At the same time they seem not to allow that the real person experiences life based on his culturally dictated and unique reality; rather, they suggest that their atypical person suffers a depressive syndrome within the framework of a rigorous Western conceptualization of depression, complete with guilt, paranoia, and sad mood, but with no measure of local variations and without regard to the unique cultural milieu: "Each diagnosis is made according to a diagnostic criterion determined before the study, and each case must conform for use in the study." Surprisingly, these criteria are not described. Even were they explicit, however, the researchers have defined depression tautologically, without reference to the particulars of the culture at hand. No doubt cases are missed with this culturally insensitive method, and conclusions based on their data are weak. None of Marsella's suggestions are followed in this study, resulting in an unrevealing glimpse at Indian depression.

The study by Nandi et al. is in contrast to that of Sethi and his coworkers (32). Sethi's work takes into account cultural differences in the experience of depression in India. It is noted, for example, that guilt is rare in Indian depressives, perhaps due to lack of a strong concept of sin in the Hindu religion. While both psychological and somatic complaints are presented, the latter are more common. In part, this is a result of the more social concept of self in India compared to Western cultures (24). The distinction is not one of mind and body, but rather of self and universe, so problems are seen to arise from the person as a whole, not simply from his mind. The study suggests that the psychopathology of the patient in India "is less florid" than is that of his Western counterpart. The investigators assert that depression may be "a social breakdown syndrome"

wherein the patient, amidst a changing society, has an unstable and unhealthy relationship between self and universe. This manifests itself more in social than in psychological dysfunction, as dictated by the Indian cultural and philosophical heritage. The Sethi study fails to develop this explanatory model of mental disorder. The researchers seem hesitant to break with Western psychiatric tradition in diagnostic criteria and disorder categories. They only haltingly embrace the first dictum in attempting cross-cultural studies and thus merely illustrate several of the more Western features in the Indian construction of depression.

Binitie claims, in his discussions of African depression (33,34), that low mood can be taken as the core symptom of depression with other symptoms as secondary. He bases this on his factor-analytic studies showing that Africans most frequently present with depressed mood in addition to various physical complaints, while Europeans tend more to experience guilt and suicidal notions along with depressed mood. In a later paper, Binitie notes that somatic symptoms "may dominate the picture to the extent that the underlying affective disorder and the depressive mood are easily missed."

Binitie finds the prevalence of depression to be quite high in Africa when diagnosis takes into account the frequency of multiple physical complaints and the dearth of ideas of sin, guilt, and feelings of unworthiness. This may be in part explained by the widely held beliefs in African cultures surrounding supernatural forces and theories of causality. These factors are more seriously considered in his more recent paper, which reflects the gathering strength of anthropological thought in psychiatry. Although his first study makes use of factor analysis, his conclusion that low mood must be present to identify cases of depression is disturbing since mood is a highly subjective category, making no mention of whether or how the norms of mood for an African would be distinguished. Binitie does not provide an adequate emic definition of depression, and his comparisons and analyses are thus not fully validated. He does not consider the symptoms with which his African patients present in light of their cultural meanings, and has thus fallen into the trap of trying "to fit clinical data into the strait jacket of Occidental psychiatric thought" (35) though the later article indicates the beginning of a departure from this mode.

Majodina and Attah Johnson question whether Africans present different depressive symptoms than Europeans (36). Their "broader diagnostic grouping to facilitate comparison" made apparent to them the similarity of the African and European samples, in that these categories contain certain "core symptoms," such as guilt and somatic distress, which appear in both cultures. It is important to note that the study included only those patients with a good understanding of English, the official language of Ghana, although most citizens of Ghana neither speak nor understand English. This selection process biases the study against those patients whose conceptualizations of depression are not influenced by Western ideas. Furthermore, most of the patients were Christians, which may account for the high number of complaints of guilt feelings, which

are seen as an unusual symptom among African depressives. It is clear that this study is not based upon culturally relevant definitions of depression and therefore it is questionable whether it even investigates the prevalence in Ghana of "Western depression," using as it does only English speaking and mostly Christian patients. Even so, within the "broader diagnostic groups" there existed, although only mentioned in passing, a difference in percentages of somatic and psychological complaints between the European and African samples, indicating that the experience of depression is indeed dissimilar in the two populations. It is in the objective factor analysis that differences between the African and European depressive experiences become apparent. In focusing on Western diagnostic criteria rather than on categories with cultural meanings, this study fails to emphasize those discrepancies shown by its own analysis. Again we see an attempt at cross-cultural comparison which fails through the use of inadequate methods, albeit it is not by the flagrant superimposition of Western labels which was once so common. The authors manipulate the categories in hope of attaining a universal depressive syndrome rather than grouping symptoms in ways which take into consideration their meanings within each culture.

Brunetti et al. recently conducted a study of depression comparing Algerian and French women, with the "underlying hypothesis that the kind of relationship the individual has with his proximal group and his larger social group and his larger social context have a great influence on his general health . . . and the degree to which he manifests anxiety and depression" (37). The study uses "impairment in daily life" to define depression and psychological discomfort, and finds that the psychopathology "is expressed in very much the same way in French and Algerian women."

Unfortunately, these investigators group an array of dissimilar symptoms together as "impairment in daily life." Their signs of discomfort and dysfunction include vomiting, migraine, joint pain, nightmares, and "feelings of unreality"—certainly quite disparate phenomena. Rather than differentiating these psychological and somatic manifestations of depression from other conditions, these researchers would view a woman with several of these symptoms to lack "satisfactory social participation." They feel that people suffer in some universal manner in reaction to unfavorable circumstances, however, the women studied are not suffering in the same way. The percentages of those suffering each complaint were recorded in both countries; there is clearly a difference between French and Algerian experiences, as the former are more psychologically manifest and the latter more somatic. Among the French, 27.2 percent had nightmares, while only 10.2 percent of the Algerians did, whereas loss of appetite was noted by only 8.8 percent of the French, but by 33.3 percent of the Algerian women. Similar discrepancies were found in most of the measures used in the study, although not all differences were statistically significant. In the search for universals, much decried by students of cultural relativism (7), Brunetti and his associates have failed to attach significance to their own evidence of unique experiences of mental disorder (24).

Karno et al. have grasped the importance of linguistic categories and avoid the "inherent category fallacy of superimposing Western psychiatric syndromes on non-Western and non-literate people who may well define and aggregate psychopathologic symptoms and experiences in culturally or subculturally unique patterns" (38). Aware of the controversies surrounding psychiatric diagnoses within the confines of individual cultures, they attempt to invoke Fabrega's ideas for "suitable vocabulary of illness-relevant (bio-behavioral) components" (39) for Spanish-speaking peoples of the New World. They are straightforward about the assumptions they make, and list some limitations of the use of their translated instrument—the National Institute of Mental Health's Diagnostic Interview Schedule (DIS).

The first assumption made in the development of the Spanish DIS was that the literal translation of English items could be appropriate to speakers of Spanish. The second assumption was that few or no entities that are defined uniquely by folk traditions, e.g., *susto* are overlooked when subdivided into symptoms such as anxiety and somatization. These assumptions are largely based on Murphy's studies of the Yoruba and Eskimos (40), which concluded that there is great cross-cultural consensus as to how emotionally ill people behave. The assumptions carry diagnostic import and seem to compromise both a rigorous application of Western psychiatric labels and true cultural relativism. As one reads the goal in the use of the Spanish DIS "to elicit *DSM-III* defined mental disorders among Hispanics," it becomes apparent that the researchers have concerned themselves with the problems of translation of Western categories, rather than with the clarification of the ways that Spanish speakers themselves experience and categorize mental illness. This forms, then, an incomplete attempt to study depression cross-culturally, for the investigators have confused the development of comparable data gathering techniques with comparable criteria for diagnosis. In the former, techniques must be similar, while in the latter, techniques must be relevant to the culture under examination. Though Karno et al. have turned these issues around, their concern with emic categories is encouraging because most researchers ignore such entities (38). There is a strong attempt to provide tools for valid cross-cultural comparisons, but complete attention to meaningful cultural differences eludes them, apparently by design.

In her paper concerning somatic and psychological symptoms among Chinese in Hong Kong, Cheung takes issue with the dichotomy between these modes of presentation (41). She observes, in detail, differences between Western and Chinese metaphysics which lead her to the conclusion that the dichotomy between bodily and emotional experiences does not pertain to the Chinese, for whom mind and body are philosophically integrated. Cheung states that an apparent lack of affective symptoms among the Chinese is situational, as somatic complaints are seen as more appropriate than psychological ones. Chinese patients in Hong Kong presumed that Western medicine, including psychiatry, is meant "to treat their physical illness." The Chinese person discusses somatic

and psychological distress in a situation-dependent context. Friends, relatives, and traditional healers are more likely than psychiatrists to hear emotional complaints, though many subtle somatic idioms are used. Cheung does well to attempt the clarification of clinical expectations and experience of affect among the Chinese, but her method of interview limits the occurrence of situational distress to indicate psychological symptoms among Chinese seeking psychiatric care. She is aware of the impact that the traditional philosophy of a culture may have on the concept of health and illness among its people, and of the problems associated with the use of a "treated case" (14) method in trying to form impressions of these concepts. She applies statistical and multi-variate analysis to her data, however the cross-cultural analysis is limited to refutations of East-West dichotomies involving somatic and psychological experience. Though this paper focuses on such dichotomies rather than the diagnosis of depression, the groundwork for further analysis is in place.

Cheung's study points to a discrepancy between popular concepts of the general public and actual symptoms presented in clinical settings. The importance of an equilibrated understanding of a culture as the foundation for the provision of appropriate psychiatric care is shown. This paper presents information which must be gathered before adequate cross-cultural studies of depression can be done. It is apparent from Cheung's article that the entire picture of cultural determinants of the experience and conceptualization of depression is not easily or impressionistically drawn. A great variety of social factors, many of which are quite subtle, influence the pattern of depression.

In his article on Saudi Arabian psychiatry, Dubovsky discusses many factors which contribute to the Saudi experience of mental disorder (42). With the intent to attract Western psychiatrists to practice in Saudi Arabia, the article emphasizes the adaptability required to "reconcile modern psychiatric approaches with ancient cultural and religious forces." Dubovsky's historical narrative of the founding of Islam considers the development of strict religious laws and punishments which shape the Saudis' behavior and beliefs. Psychiatry is placed in the light of "Islamic law, folk concepts of mental illness and twentieth century knowledge," indicating that social matters greatly influence the practice of psychiatry in the Kingdom. Folk concepts such as *in 'shallah*—as God wills—prevent complaint and hamper compliance since outcome is seen to rest completely in God's hands. Explanations of traditions and folk beliefs foster an understanding of roles dictated by Saudi culture and of conflicts arising when ancient traditions and beliefs come face to face with modern technologies and ideas.

Dubovsky suggests that creativity and fluency in Arabic are prerequisites for Westerners in the practice of psychiatry in Saudi Arabia. Diagnosis using standard mental status examinations is difficult among the many Saudis who are illiterate or among "patients who have never held a pencil" since "tests suited to this population have not yet been devised" (42). Depression is often presented as multiple somatic complaints "which generally are a more acceptable means of

seeking attention." Biological factors are joined by psychosocial determinants of depression in such a way that the cohesive family unit and strongly conservative society must be understood in order to diagnose and treat depression. Dubovsky notes that psychiatrists "are bound to become frustrated if they do not realize" the power of "folk concepts of mental and physical illness," the traditional roles of man and woman, sick and well, and the conflict of past with present in technology and life-style. He stresses the importance of an ability to empathize and to work within systemic cultural idiosyncracies in practicing psychiatry in Saudi Arabia.

Dubovsky's points are applicable to the practice of psychiatry in any culture. His discussion of the historical, economic, religious, and social variables affecting the individual is a necessary step toward understanding the Saudi experience. These factors need to be considered in every study of depression in foreign and, indeed, domestic cultures as the foundation from which sick roles, illness behaviors, and explanatory models develop, and as shapers of the various experiences of depression by members of all cultures.

## DISCUSSION

Only with culturally meaningful definitions of depression can researchers begin to study its prevalence in foreign cultures. Marsella's admonition that emic definitions be used is well-founded, for only when the category under examination has meaning for the people involved can the results of such studies be valid. Depressive phenomena evidence cohort-specific idioms of clinical distress. These can lose meaning when "translated" into the "language" of another culture. These emic features of depression are epigenetic elaborations of culture, based on a biologic core. Our understanding of this biologic core is developing. Common features of an emically-derived, ethnopsychiatric epidemiology of depression are one means by which the generic aspects of biologic depression in *Homo sapiens* can be disentangled from any cohort-specific idioms. This is a powerful, if presently cumbersome, avenue of investigation, and may be the primary focus for ethnopsychiatric epidemiology. The idioethnic experience of depression within specific cultures is another important focus which must be understood by researchers and clinicians alike. This latter focus has long been emphasized by anthropologists in the guise of cultural relativism, but psychiatrists since Kraepelin have stressed Western models of depression. In any case, the major features of depression and their culture-dependent aspects must be established in specific cultural cohorts before strong cross-cultural studies can be done.

A principal aim must be to define, by cross-cultural comparisons, the universal symptoms of depression that remain in counterpoint to culture-specific features. Common findings in almost all the studies reviewed are depressed affect and "somatic complaints" or neuro-vegetative signs. Indeed,

perhaps "somatic complaints" are neuro-vegetative signs which are under-emphasized in Western diagnosis due to their heterogeneity.

What other universal features may emerge? Certainly treatment response is an area of importance which has not been assertively studied cross-culturally. Family history reviews for the same or similar conditions are needed. Of course, the typical natural history of individual illness would be useful to know in cross-cultural context.

Once the cultural realities of depression and its pleomorphic explanatory models have been described, coordinated data gathering and objective analyses can take place across cultural boundaries. Only then can the generic aspects of depression in *Homo sapiens* be distinguished from its culture-specific elaborations. The recent literature shows burgeoning interest by psychiatric researchers as the essential ideas begin to take root and unfold. With care and effort anthropological psychiatry may lay fallow scientific "colonialism" and reap a harvest of better diagnoses, care, and outcome of depressive disorders worldwide.

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