

Introduction: Culture and Depression

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CULTURE AND DEPRESSION: INTRODUCTION TO THE PROBLEM

Why should a group of anthropologists, psychiatrists, and psychologists devote a volume to culture and depression? Historians tell us that the Greek and Roman medical writers described “melancholic diseases” among their populations which are quite similar to those seen by psychiatrists today, and that the terms “melancholia,” “depression,” and “mania” have a long and relatively stable history in European thought. Although writers such as Robert Burton, whose compendious *Anatomy of Melancholy* (1621) summarized clinical lore of his day, sought causes for the disorder in the black bile and described subtypes of melancholia that ring strange today, there seems little question that the ancients suffered depression as do people today. Furthermore, psychiatrists practicing in Third World clinics and mental hospitals see patients who are recognizably depressed and treat them with medical regimens current in Western clinics, including antidepressant medications and supportive therapy. This apparent universality arouses no surprise among contemporary biomedical researchers, who believe depression is a disease that is found in all human populations and that we are just beginning to understand. During the past decade, enormous strides have been taken in unraveling the complex set of interacting biochemical and psychological processes which produces depression. Although the picture is not as clear as many researchers thought five years ago, there is little question that neurotransmitters—bioamines involved in the transmission and regulation of neurological messages—and a set of hormones are implicated in depressive illness. So what is cultural about depression? What

do anthropologists or cross-cultural psychiatrists have to offer to an understanding of such a disorder? Is there reason to believe that life in some societies is organized so as to protect their members from depressive illness? Is there evidence that the condition looks quite different in some cultures?

Growing evidence indicates the issues are not as clear as this picture of depression as a universal disease would suggest. First, the study of depression continues to be plagued by unresolved conceptual problems. Depression is a transitory mood or emotion experienced at various times by all individuals. It is also a symptom associated with a variety of psychiatric disorders, from severe and debilitating diseases such as schizophrenia to milder anxiety disorders. It is also a commonly diagnosed mental illness. Depression is thus considered mood, symptom, and illness, and the relationship among these three conceptualizations remains problematic. Is depressive illness a more severe and enduring form of depressed emotions, or is it an altogether different process? Are the boundaries between depressed mood and illness simply conventional, or are they related to more essential differences between them? Are depressive illnesses really discrete forms of pathology, separate from anxiety disorders, for example, or is depression a symptom—like fever—that may be associated with any number of disorders? These basic questions continue to bedevil researchers and preclude clear analysis of depressive illness.

Reading through the history of changes in conceptualization of the subtypes of depression does not give one confidence that such problems are about to be solved once and for all. The history of psychiatry is strewn with “nosologies,” or systems of categorization of depression. Some are etiological categories, such as endogenous and reactive, reflecting interest in the underlying cause of a depression. Other distinctions, such as that between primary and secondary depressions, are relational, designating which is to be considered the illness, which the symptom. Other categories, such as neurotic and psychotic, are descriptive, indicating characteristics and severity of the disorder. The current wisdom, represented in the American Psychiatric Association’s most recent Diagnostic and Statistical Manual (DSM-III), eschews cause altogether, treating psychiatric disorders as unitary diseases, precipitated by social precursors and superimposed on enduring personality characteristics. But is the depression of a basically healthy individual with unresolved grief over loss of a spouse or child the same disease as a depression of a more fundamentally troubled person? Anthropologists are not, of course, the first to raise questions such as these. They are

debated regularly in the psychiatric literature. To the anthropologist, however, such disagreement over basic terms is a reminder that we are in the presence of culture. Psychiatric categories and theories are cultural, no less than other aspects of our world view. It seems reasonable, therefore, to ask to what extent depression itself is a cultural category, grounded both in a long Western intellectual tradition and a specific medical tradition.

Cross-cultural research offers evidence of cultural variations in depressive mood, symptoms, and illness which suggests the importance of pursuing this question. “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. For Buddhists, taking pleasure from things of the world and social relationships is the basis of all suffering; a willful dysphoria is thus the first step on the road to salvation. For Shi’ite Muslims in Iran, grief is a religious experience, associated with recognition of the tragic consequences of living justly in an unjust world; the ability to experience dysphoria fully is thus a marker of depth of person and understanding. Some societies, such as the Kaluli of Papua New Guinea, value full and dramatic expression of sadness and grieving; Balinese and Thai-Lao, by contrast, “smooth out” emotional highs and lows to preserve a pure, refined, and smooth interior self. Members of such societies vary not only in how they express dysphoric emotion; they seem to experience forms of emotion that are not part of the repertoire of others. So dramatic are the differences in the cultural worlds in which people live that translation of emotional terms requires much more than finding semantic equivalents. Describing how it feels to be grieved or melancholy in another society leads straightway into analysis of different ways of being a person in radically different worlds.

What anthropological evidence we have indicates differences not only in depression as mood but also in symptoms of depressive illness. For members of many African societies, the first signs of illness are dreams that indicate a witch may be attacking one’s vital essence. For members of many American Indian groups, hearing voices of relatives who have died is considered normal, not a sign of sickness. For members of other societies, hearing voices or dreaming of spirits may indicate a member of the spirit world is seeking a victim or demanding to establish a relationship with one who will become a follower and perhaps a healer. Dramatic differences are also found in expression of bodily complaints associated with depressive illness, indicating forms of experience not available to most members of our own society. Nigerians complain that

“ants keep creeping in parts of my brain,” while Chinese complain of exhaustion of their nerves and of their hearts being squeezed and weighed down. In few societies of the world is depression associated with overwhelming guilt and feelings of sinfulness, as it often is in the Judeo-Christian West. Because such differences are found in the symptoms associated with depressive illness, determination of whether one is studying the same illness across societies is essentially problematic. There is no blood test for depression. If there were one, it would indicate some physiological disorder, but not the fundamentally social illness we call depression. Since symptoms serve as the criteria for depressive illness, and since symptoms vary significantly across cultures, the difficulty of establishing the cross-cultural validity of the category “depression” must be faced.

The world’s cultures have offered researchers of various disciplines a natural laboratory for investigating the relation between depression and contrasting systems of social organization and cultural meanings. Questions asked reflect the theoretical orientation of the discipline and period. For years, psychoanalytically oriented researchers attempted to test theories of depression as aggression directed against the self, and to maintain the theory in the face of evidence that depression is often not associated with feelings of guilt and self-depreciation, and that the anger experienced by those who are depressed is commonly expressed toward others. Cross-cultural epidemiologists have sought variations in rates of depressive illness across societies, then looked for aspects of social life and culture that would explain the variance. Clinical researchers have looked at differences in levels of somatic and psychological symptoms across patient populations, some offering explanations of these differences in terms of the evolution of societies.

Although questions of the role of social and psychological factors in placing individuals at risk or protecting them from depressive symptoms and illness have great currency and are appropriate to put to the cross-cultural evidence, this book is organized around a prior question: Does the concept of depression have cross-cultural validity? Do members of other societies experience what we call depressive emotions and major depressive illness? Do differences in cultural meanings significantly alter the experience of depressed mood and the symptoms of depressive illness? If so, how are we to translate between our emotional world and those of other societies; how are we to establish criteria for depressive illness in other societies which will be comparable to those we use in our own?

In a sense, the great advances in biological psychiatry provoke these questions. Discovery of effective antidepressant medications in the 1960s initiated the most active period in the history of research on depression. Identification of effective psychopharmacology allows researchers to follow a strategy of comparing individuals for whom the drug is effective with a normal population and of investigating physiological changes in the individual which result from the medication. Both of these strategies are aimed at discovering biological mechanisms that correlate with depressive illness. In order to undertake such research, however, reliable diagnoses of depression must be made to serve as a basis for identifying samples to be studied. By the mid-1960s, it was clear that basing diagnoses on the "clinical judgment" of psychiatrists was unreliable. The same patient was likely to be diagnosed schizophrenic in the United States and manic-depressive in Great Britain, for instance.

To facilitate such research, the National Institute of Mental Health sponsored a major effort to establish clear diagnostic criteria for psychiatric disorders. These efforts resulted in a dramatically new diagnostic manual and innovative epidemiological instruments designed to assign psychiatric diagnoses to individuals (as contrasted with older instruments designed to determine level of psychiatric symptoms). Because these new diagnostic instruments are proving reliable, and because they are useful in identifying individuals with particular physiological as well as psychosocial characteristics, there is growing consensus in the psychiatric community that the current criteria of depression are valid and represent criteria of a universal, biologically grounded disease. It is just such certainty that our Western categories, in this case disease categories, are universal rather than culturally shaped which provokes anthropological response. When medical researchers act on an assumption of universality by directly translating our own diagnostic criteria into other languages to determine who is mentally ill in another society, anthropologists may be expected to challenge the validity of the entire enterprise.

This volume is designed to examine these issues. It represents the editors' conviction that cross-cultural research is of extraordinary importance in advancing our knowledge of human behavior, psychiatric illness, and, in particular, depression. It also represents our belief that disciplinary boundaries have greatly impeded examination of the questions raised here. Anthropologists often have little or no clinical experience and consequently criticize the psychiatric literature based solely on

their research with normal populations. Psychiatrists seldom have extended experience with non-Western populations and consequently *underestimate* the great difficulty of translating between our Western analytic schemes, grounded as they are in our tacit cultural knowledge concerning emotion, interior experience, and psychological disorders, and the very alien psychological worlds of many of the societies studied by anthropologists. Epidemiologists so struggle to develop reliable approaches to measuring psychological disorders and social factors that they seldom seriously confront issues of validity. These great differences in perspectives have prevented the kind of serious scholarly exchange necessary to advance our understanding of depression in the context of cross-cultural studies.

This book is addressed to an interdisciplinary audience of researchers, scholars, and lay readers. We asked the authors—a distinguished group of anthropologists, psychiatrists, and psychologists—to present original data concerning depression in the societies they have studied, to address fundamental theoretical issues, to outline methodological issues raised by their work, and to engage members of other disciplines explicitly. Several common themes emerge from the contributions. The chapters submit the dominant psychiatric conceptualization of depression, in particular that represented by DSM-III, to sustained cultural analysis. Although there is no simple consensus about the cross-cultural validity of Western concepts of depression, the chapters document how differently dysphoric affect is interpreted and socially organized in many societies and suggest that depressive illness takes culturally distinct forms in several of the societies studied. The authors thus challenge current conceptualizations as parochial, as a form of “local” knowledge, and attempt to reinterpret “emotion,” “symptom,” and “illness” in thoroughgoing social and cultural terms. However, they do not stop at anthropological critique. A number of the contributors go on to outline research programs and to provide data, at times based on joint ethnographic, clinical, and epidemiological work, that significantly advance our understanding of the role of culture in shaping dysphoria and depression. We believe these contributions lay the ground for a new anthropology of depression.

ORIENTATIONS

Three distinctive disciplines dominate the cross-cultural study of depression: anthropology, psychiatry, and psychology. Though each has been

interested in this subject for decades, they have gone about the descriptive and comparative tasks in separate ways, so that, as in the more general study of emotions and mental disorder cross-culturally, each discipline has constructed a more or less discrete literature. Theories have differed as much as methods, and within each discipline contributions have ranged along a spectrum of theory from materialist to idealist (Hahn and Kleinman 1983). So separate have these traditions become that one finds in each few references to recent work outside that tradition. If there ever was a situation accurately captured by the image of the blind men and the elephant, this would seem to be it.

This volume is an attempt to overcome the obvious and unavailing limitations that such splendid isolation creates. We have assembled papers from each tradition and asked contributors to deal with contributions from the other fields. Each contributor was also urged to set out fairly explicitly his or her theoretical paradigm and to illustrate it by working through empirical materials. The results vary, as they will in a large collection, but we the editors believe that taken together they portray (warts and all) both the present state of these distinctive disciplinary approaches to understanding culture and depression and the opportunities for and barriers to interdisciplinary colloquy and collaboration.

This volume is neither exhaustive nor truly representative. Rather, it reflects the chief preoccupations of the editors. We believe the biological component of clinical depression is important and cannot be disregarded, but we also share the view that biological studies divorced from clinical and ethnographic investigations have little to contribute to our understanding of the relation of culture and depression. Hence we have not sought to include a paper on this latter approach. During the preparation of the chapters, however, contributors were sent relevant reviews of the biology of depressive disorder, along with other papers on clinical, epidemiological, experimental, and ethnographic approaches, so that their discussions might include some attention to biology.

Similarly, because it is now so well known, we have not felt the need to include a strictly psychoanalytic account, though several of the contributions are informed by a psychoanalytic perspective. In place of a narrow experimentalist exposition, we have elected to have the relevant elements of this research tradition discussed in a more broadly based review of leading psychological research traditions. We have also eschewed sociological accounts that treat depression totally as an ideological or moral phenomenon, since with William James (1981:1068) we hold that "a purely disembodied human emotion is a nonentity."

What have we chosen to emphasize? Because it is our view that the

single most troublesome problem plaguing the cross-cultural study of affect and affective disorder is the failure to take an anthropologically sophisticated view of culture, we have emphasized anthropological accounts, especially those that regard culture as the intersection of meaning and experience. We believe the cross-disciplinary study of culture and depression will be best advanced by coming to terms with the analytic questions raised by these accounts, and by critically examining the ethnocentric bias of psychiatric and psychological research categories. We also hope to stimulate further research in this tradition, especially studies that confront what we take to be a long-term weakness of anthropological accounts and the field's second most serious problem: a failure to grasp the clinical dimensions of depression. Hence we have included clinical and epidemiological studies that bridge anthropological and clinical frameworks. We have also sought out contributions that represent what we take to be some of the more innovative and productive approaches to the interdisciplinary study of emotion in society: sociolinguistic, cognitive behavioral, developmental, ethnoepidemiological, and sociosomatic analyses. Our bias is clearly integrative. Only accounts that relate meaning with experience, symbol with soma, culture with nature, and the three disciplines with each other, can overcome the sources of failure that have undermined most cross-cultural research on depression and mental disorder generally.

DEPRESSION: EMOTION OR DISORDER?

The contributors to this volume discuss two divergent forms of depression: depression as emotion and depression as disorder. It is important that the reader recognize which is the object of inquiry. For anthropologists, whose chief concern is the system of normative meanings and power relations which mediates the interconnections between person and society, emotions—here as personal feelings, there as expressions and constituents of social relationships—are commonly the focus of attention; not so for psychiatrists, whose interest centers on clinical disease.

Depression, then, simultaneously stands for two distinctive states of persons: one normal, the other pathological. But this distinction is usually not made in writings on depression in different societies and among ethnic groups in the same society. The result is a confusion so pervasive that researchers in this field often fail to agree or disagree with each other with adequate clarity to advance understanding. The contribu-

tors to this volume were asked to avoid this confusion, and we think for the most part they have. But if writings on depression as emotion and depression as disease are discourses about different subjects, how do these subjects relate? Here the reader will find the chapters reflect the chief ways of configuring this conundrum which dominate the literatures on depression. For some, there is a continuum between psychological state and clinical case, while for others the two are qualitatively different. For still others, each is a reification of Western categories which becomes problematic when viewed from the perspective of indigenous non-Western categories.

For the clinician, depression is a common, often severe, sometimes mortal disease with characteristic affective (sadness, irritability, joylessness), cognitive (difficulty concentrating, memory disturbance), and vegetative (sleep, appetite, energy disturbances) complaints which has a typical course and predictable response rates to treatment. Thousands of studies implicate neurotransmitter, neuroendocrine, and autonomic nervous system malfunctioning, and there is even early evidence, any biologically oriented psychiatrist will tell you, of genetic vulnerability. This is not the "depression" of the ethnographer, for whom the word denotes a feeling state of sadness, hopelessness, and demoralization that may be as fleeting as a momentary nostalgia or as lasting as prolonged grieving. For the clinician, grief is not clinical depression, though it may become so; for the ethnographer, depression is often conceived as a form of grief and grief as a type of depression. Psychologists oscillate between the two positions. For some behaviorally oriented psychologists, there is no "disease," though there most definitely is abnormal or maladaptive behavior; while for the psychoanalytically oriented, the two (emotion and disorder) partake of continuities and differences. In making headway through the chapters that follow it is essential that the reader know which one of these language games he or she has entered.

Other tensions characterize the field and are visible throughout the volume. Ethnography and epidemiological surveys sharply pose these differences. The former is qualitative and concerned principally with the problem of validity. The latter is quantitative and concerned primarily with the problems of reliability and replicability. The ethnographer masters the local language, spends many months, even years, in the field, and develops close working relationships with a relatively small number of key informants. He or she concentrates on translation and interpretation of meaning, often working with tacit and hidden dimensions of the social system. The epidemiologist spends weeks, at most a

few months, in the field, usually does not know the indigenous language, and hence is forced to rely on questionnaires and measures of “observable” and “quantifiable” behavior. The epidemiologist views the ethnographer’s task as “impressionistic,” “anecdotal,” “uncontrolled,” “messy,” “soft,” “unrigorous,” “unscientific”; the ethnographer, in near perfect counterpoint, regards the epidemiologist’s work as “superficial,” “biased,” “pseudoscientific,” “invalid,” “un-scholarly.” Two unequal responses to this tension are apparent: the much more common—though to our minds less creative—is to put on blinders and disregard the work of the other; more rarely, researchers attempt to combine the two methods. Examples of both can be found in this volume.¹

If anthropological ethnography and epidemiology differ fundamentally as methodologies, the clash between anthropology and psychology is one of conflicting paradigms governing what can be legitimately regarded as knowledge. Psychologists in the cross-cultural field do epidemiological, social survey, and clinical research. A few even make use of ethnographic methods, and many more utilize cross-cultural comparisons not all that different from those in which anthropologists engage. But it quickly becomes apparent their hearts are really in the experimental method. Underlying the method is an assumption that knowledge of human behavior, like that of the physical world, is generated by finding culture-specific instances of universal variables, then discovering laws that account for their covariation. Anthropologists generally scale another form of knowledge, based on interpretation of individual cases and careful translation across cases to make controlled comparisons. These approaches produce very different ideals of research, data analysis, and writing, and result in products as different as detailed ethnographies and short reports of statistical analyses. The epistemological paradigms of research practice in each field yield different kinds of knowledge, expressed in divergent styles and validated by distinctive tests of validity.

Although these differences prevail, anthropologists, psychologists, and psychiatrists increasingly combine methodologies. Psychological anthropologists have been strongly influenced by the core psychological methodology, and have imported it into field research. Psychiatrists have traditionally scorned all these approaches for clinical research methods of direct observation and counting of symptoms, charting of illness course, and evaluation of treatment outcomes. More recently, however, they too have employed epidemiological and social surveys, cross-cultural comparisons, and experimental research design. Only a few

have felt comfortable with ethnographic methods, however, in spite of there being a long tradition of interpretive methodology in psychoanalytic, existential, and phenomenological clinical research. In each discipline, moreover, these tensions can be found among distinctive groups or schools of researchers. Increasingly these crosscutting research traditions have brought together scholars from the different disciplines.

We hold that these tensions in orientation—clinical/academic, quantitative/qualitative, meaning-centered/behavior-centered, cultural analysis/biological analysis, and so forth—represent a creative dialectic in cross-cultural studies, one that advances each discipline as much as it revivifies the subject. To exploit these scholarly tensions systematically, we have juxtaposed one kind of scholarship with another, mixed the traditions in which they are used to tackle the same set of problems, and in the final section of this book, presented three chapters that represent attempts to construct an interdisciplinary anthropological psychiatry (or epidemiology) and psychiatric (or epidemiological) anthropology. This strategy reflects a growing (though still minority) awareness that the old, established disciplinary approaches have led to dead ends. They increasingly appear conceptually and methodologically inadequate for their task, their products repetitious and off the mark. There is interest in new directions, new ways of configuring old problems as much as new methods for studying them. The field is starting to change, as scholars in each of the disciplines come to recognize the need for a new language to talk about sociosomatic and psychocultural interconnections, new paradigms of how to do research which integrate ethnographic and experimental methods and account for the *interaction* of nature and culture in the production and shaping of human distress.

We suggest that for each chapter the reader ask the following questions, which run like unifying threads through materials that are not nearly as disparate as they may at first glance seem, or as divergent as some of their authors would hold. Is depression configured as affect, affective disorder, or both? If as emotion, what view of emotion does the author hold—that emotion is a single state of arousal that is then shaped into anger, sadness, anxiety, or that particular emotions are from the start psychobiologically distinctive affective states? Is emotion configured as precognitive, cognitive, transactional, ideological, or various combinations of these?

For those papers dealing with affective disorders, the reader will want to ask: How do the authors define depressive disease (the end of a quantitative continuum or a qualitatively different clinical state)? Is a

distinction drawn, and if so how is it handled, between depressive disease (expert's construction) and depressive illness (lay construction)? Where depression is configured as behavior, how is abnormal behavior distinguished from disease? How is normal depressive behavior thought to relate to the feeling state of being depressed? What are taken to be the sources of normal and abnormal depressive behavior, or depressive affect and depressive disorder?

How is culture configured, and what is the vision the writer holds of its interaction with depression? In what ways do the interpretations of how culture relates to depressive affect contrast with the interpretations of how culture relates to depressive disorder? What do these interpretations tell us about the particular societies under study, on the one hand, and about the study of normal and abnormal human experience, on the other? Do these distinctions, when applied to the practical reality of lived experience, matter clinically?

What are the universal and what the cultural varieties of depressive experience (be it emotion, disease, or behavior)? What are the sources of these continuities and divergences? Do cultural similarities and differences hold across gender, social class, and age? What opportunities do given chapters present for cross-disciplinary colloquy? What are the limitations authors foresee in the other perspectives, or in their own? What do each view as the salient questions in the cross-cultural study of depression?

While other questions also come to mind, these strike us as a grid that should help readers relate the chapters. Since many readers are likely to bring to the volume one of the disciplinary perspectives reviewed above and all will come to the chapters with particular theoretical assumptions, the reader may take this opportunity to search for relationships among chapters and thereby situate his or her particular perspective in relation to others. We see this conceptual tacking between divergent orientations as a means to liberate one's perspective from the tacit biases that confound all approaches to this subject. Those of us whose work is presented here have attempted to do this, albeit with mixed success. Anthropology suggests every cross-cultural encounter should make the challenge to particular perspectives unavoidable.

Our problem framework must be broadened to ask what the cross-cultural study of depression tells us not only about the social sources of depression but also about society. This anthropological orientation forces us to address both the impact of depression on society and the insight the social antecedents and consequences of depression provide into the nature and varieties of culture. Here then is yet another tension,

this time between person and society, that can be avoided only at the expense of a more discriminating understanding. The creative dialectic between the two foci of interest centers our analysis on the symbolic bridge linking psychobiological and social realities.

OVERVIEW OF THE CHAPTERS AND THEIR ARGUMENTS

The following comments are our reflections on the important ideas raised in each of the papers and our interpretations of the relationships among them. They are the result of our having lived with these papers over the past two years and our attempt to come to terms with them based on a close reading. We share these fairly detailed comments with readers as reading notes that point up shared themes and special questions that will engage the reader's close reading.

Part I includes four anthropological pieces and a historical contribution. In chapter 1, Jackson describes the historical anthropology of two dominant Western idioms for configuring dysphoria: melancholia and acedia. He shows that their history is closely linked to changes in Christianity and medicine. Each took on different meanings at different times, and altered the meanings of the other. From the medieval period acedia in the religious texts became an interior quality like sorrow, while in the popular idiom it continued to radiate earlier meanings of a moral nature (sloth). At one time it conveyed an internal state, at another time an external behavior. Eventually it lost its coherence as a distinct condition in the West. Melancholia, in turn, came to mean both the disease and the affect. From the sixteenth century, with the transformation of Western society from a religious to a more secular state, acedia and the other cardinal sins gave way to the four temperaments and the humoral theory of behavior. Jackson shows that both acedia and melancholia mapped symptoms of great historical continuity across epochs as well as changing styles of symptom perception, expression, and labeling. Jackson demonstrates especially melancholia's changing association with distinctive explanatory idioms in Western history: somatic, psychological, religious, or moral. Hence the historical antecedents of "depression" disclose differing meanings, the remnants of which lend to "depression" today its ambiguous symbolic significance in lay and professional usage. The great virtue of this historical account is its demonstration of the anchoring of religious, illness, and behavioral categories in changing social structural arrangements. We may have moved from acedia and melancholia to depression, but we are warned of

the same process that makes untenable the asocial, ahistorical professional tendency to reify names as things. Yet Jackson's diachronic analysis also indicates that beneath the flux and flow of social reality some continuing forms of human misery show a perduring, obdurate somatic grain. This grain clearly constrains experience as much as do the mutable categories that model it and the social arrangements that are the sources of such misery and shape the categories themselves.

Lutz (chap. 2), a psychological anthropologist, sketches a cultural critique of professional psychological categories—such as the emotion/cognition, subjective/objective, mind/body dichotomies—that she shows are tacit epistemological axes of the Western cultural tradition. Professional psychology and psychiatry draw on the West's ethnopsychological and ethnomedical systems. This creates an implicit ethnocentrism that only becomes apparent when our academic categories are contrasted with those of non-Western peoples. Translating the concept "depression" involves the translation of Western ethnopsychological and ethnomedical concepts of the nature, antecedents, and consequences of behavior which differ substantially from non-Western formulations of normal and abnormal behavior. Lutz's ethnography discloses that "thought" among the Ifaluk, a people living on a tiny South Pacific island, is not separated from "emotion," nor is depression seen as the opposite of the pursuit of happiness and equated with joylessness (anhedonia) as in the West. Depressive emotion as it is technically operationalized in psychology is a Western cultural category. Lutz suggests that emotion is best conceived not as psychobiological process but as cultural judgments that people use to understand the situations they find themselves in. These judgments are negotiated interpersonally and mediate events and relationships. Emotions, which are always embedded in ethnopsychological systems, support judgments concerning fact or value. They define situations, legitimate action in the real world. For this reason, Lutz argues cross-cultural psychological studies must break out of their ethnocentric cast by replacing the cross-cultural study of depressive affect with investigations of indigenous definitions of situations of loss and blocked goals and the socially organized response to them.

Lutz presents the strong argument in anthropology for the ethnocentric, egocentric and medicocentric biases of psychology, and offers a new problem framework for cross-cultural psychology. Her chapter is a *vade mecum* containing virtually all the major anthropological criticisms of psychological approaches applied to non-Western peoples. She shows

why ethnography of others' emotional lives should lead to the discomfiting recognition that our very categories for doing the human sciences are culturally shaped. Her analysis is a challenge to cross-cultural research: translation—so often taken for granted in psychological and psychiatric studies—calls into question the very enterprise itself. Her refusal to privilege biological bases of emotion is likely to upset psychiatric readers as much as her cultural critique may provoke psychologists, and the colloquy that results will have to confront the limitations of relativism.

In the next chapter, Schieffelin extends the anthropological argument. Emotion is viewed as a system of social behavior, having a structural component external to personality and located in a social field of behavior, not just in the inner self. Schieffelin avers that affects are social inasmuch as they are experienced and provided with meaning in relationships with others, organized by cultural rules of expression and legitimacy, and communicate cultural messages. They are socially expected and even required as part of the appropriate participation in situations. Drawing on his extensive ethnographic experience with the Kaluli, a small-scale, preliterate society in the Highlands of Papua New Guinea, Schieffelin, following Bateson, uses the concept of "ethos"—a culture's style of expressing emotion and model for emulating how to articulate emotion—to analyze how the Kaluli's egalitarian social structure of balanced reciprocity supports an ethos of male personal dynamism and assertiveness as well as dependency and appeal which gives a unique cultural form to anger and depression, respectively. The cultural value of balanced reciprocity is shown to be as relevant to Kaluli emotional behavior as it is to their economics. Schieffelin illustrates how this local system of the emotions operates by describing how the Kaluli handle grief reactions. He shows that their bereavement rituals constitute and express a movement from grief to anger and effective action. In these rituals the bereavement experience is resolved and the grieving person supported and compensated in keeping with the norm of reciprocity. The Kaluli, who do not recognize depression or have a label for it, appear to Schieffelin to suffer little of it (only one case in the villages he has worked in over the years). Schieffelin's analysis supports a psychoanalytic interpretation of how this cultural system protects the Kaluli against depressive disease, a not uncommon outcome of prolonged or abnormal grief in the West. Switching to a learned helplessness model of depressive disease, Schieffelin analyzes the single case of depressive disorder he encountered among the Kaluli as the result of that society's

rather rare production of learned helplessness. This case of somatized depression is a harbinger of the discussions of somatization in chapters 9 through 13.

Schieffelin argues that if human affect is constituted in a social field, then affective disorders must also be essentially social phenomena. If this is so, then therapy must engage the sufferer in the social and cultural views in which the illness has its grounding. Schieffelin illustrates this by outlining a hypothetical therapy that would be specific to Kaluli society in the treatment of depression. This approach has the heuristic value of demonstrating how different a Kaluli treatment of depression would have to be from American treatment. It demonstrates the fundamentally cultural quality of depression and suggests we consider our therapies, including Beck's (1976) increasingly popular cognitive therapy, as a cultural response to a cultural disorder.

In chapter 4, Obeyesekere continues the anthropological line of analysis, but does so with a startling assertion. The generalized hopelessness that Brown and Harris (1978) and many others now take to be the basis of depressive disorder, Obeyesekere contends, is positively valued in Sri Lanka, as the foundational Buddhist insight about the nature of the everyday world. Pleasurable attachments to people and things in the world are the roots of all suffering, and recognition of the ultimate hopelessness of existence makes transcendence possible. Obeyesekere regards depressive affect in the contemporary Western world as "free-floating," not anchored in a shared societal ideology, and for that reason it conduces to medical labeling as illness. In Buddhist society private depressive affect is articulated in a publicly shared religious idiom, which echoes Jackson's discussion of *acedia* in medieval Europe. The "work of culture," Obeyesekere reasons, following the writings of the French philosopher, Ricoeur, involves the transformation of affects into meaning, providing unorganized and disorganizing private distress with a public form. For example, Freud argued that mourning is "work" that overcomes distressing affect engendered by loss. By means of the work of culture, feelings of loss become articulated as publicly sanctioned meanings and symbols, and in that movement from private world through social ideology to public symbol the feeling is mastered. Yet Obeyesekere openly admits some disquiet with this formulation, because, though it may explain what happens for the great majority, it does not explain those cases in which the work of culture fails to prevent the person from experiencing depression as disorder. Here he suggests that research is needed to determine the precise social structural, economic,