As a medical anthropologist who works at the interface of culture and mental health, I am keenly interested in the ways in which people talk about the nature of their distress and illness. These forms of discourse, for me, serve as a means of entry into the models that they employ to make sense of emotional and psychological problems. Over the years, my interests have encompassed a number of disorders, from alcohol abuse and dependence through post-traumatic stress disorder. However, depression was the first to capture my attention and remains among the most intriguing illnesses to understand in terms of its phenomenology, manifestation, as well as treatment across different cultures (Kinzie, Manson, Do, Nguyen, Bui, & Than, 1982; Manson, Shore, & Bloom, 1985). In this chapter, I hope to convey how the struggle to understand the content, form, and meaning of depression among the people with whom I work leads us to reconsider many of the basic assumptions that we may have about the world around us and our way of viewing it.

In 1978, having just completed my doctoral work, I joined the faculty in the Department of Psychiatry at the Oregon Health Sciences University. During the first few months of that appointment, it became clear to me that if I wished to pursue a career investigating the relationship between culture and mental health, I needed to properly equip myself for this endeavor. Consequently, as an anthropologist, a logical first step was to focus on the practices of the colleagues around me. Thus, I undertook a clinical fellowship that spanned two years, and took me into the local psychiatric emergency room every week. There I observed, and later employed, structured diagnostic techniques. This experience gave me a firm grounding in the nosology that guides modern-day psychiatry. Sitting with psychiatric residents in training and intermittently supervised by my colleagues, I gradually learned the logic and language by which they brought coherence to the illnesses presented by their patients.

This logic is codified as the American Psychiatric Association’s *Diagnostic and Statistical Manual*, commonly referred to as the *DSM*. There have been, to date, three major editions of the *DSM*; presently the field operates in terms of the third version, which was revised in the mid-1980’s. Work is underway on a fourth edition, which will appear in

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1993. I return to this development at the close of the chapter, indicating how some of the lessons that I and others have learned over the years are informing the latest revision of this taxonomic system.

During the early phase of my clinical fellowship, I was amazed at the extent to which fellow trainees and supervising clinicians gleaned similar insight from the stories that they elicited from their patients: the words that they found important, the themes that they attempted to articulate, and the consistencies or inconsistencies that they found therein. Over time, I acquired a similar ability to identify elements of patients’ discourses that my peers and teachers considered important. However, I also spent a great deal of time in the reception area, observing patients and their family members upon entry to the emergency service. Visiting with them there, I noticed that they tended to speak differently about their problems, using not only other words and phrases, but emphasizing different aspects of their experiences than did my colleagues. I decided to study this matter more systematically.

I began by searching many sources for words and phrases that may be used to describe depression and anxiety; the most common complaints voiced in this clinical setting. I scoured textbooks, journal articles, even biographical accounts of the mentally ill. Eventually, I accumulated 100 words or phrases frequently associated with depression and anxiety. Each word or phrase was carefully reproduced on a 3” × 5” note card. I began interviewing individuals using these words or phrases as stimuli.

The groups of interest to me included white middle class U.S. patients attending an adult outpatient clinic at the university where I worked; American Indian patients seen in an adult outpatient clinic at a service unit on a Northwest reservation; and psychiatric residents in training (virtually all of whom were from white, middle or upper class backgrounds). Over a five-year period I interviewed nearly 150 individuals in each of the patient groups and approximately 75 psychiatric residents.

The interview revolved around a fairly simple task, called a Q-sort procedure. Specifically, I presented each individual with the same stack of 100 3” × 5” cards and asked him or her to flip through it one-by-one, placing each card in a pile that represented words or phrases that she or he believed “belonged together.” There was no limit to the number of piles that a person might construct or to the number of cards that could be placed in any given pile. Individuals were permitted to change their minds (and often did) about which cards they wished to assign to certain piles; they even lumped and split piles as the process unfolded. The only constraint was a 10-minute time limit that I imposed on this task: many people became so engrossed in sorting the cards that they lost all track of time! Having finished, I questioned each individual about how she or he approached the task: “Why did you group these cards together in this (each) pile?” “What is the common feature(s) among them?” “What distinguishes one pile from another?” “Are certain piles more or less like some than others?”

This procedure provides a quick means of eliciting the cognitive maps by which people order phenomena in their everyday world. Anthropologists, linguists, and cross-cultural psychologists, for a long time, have used such techniques to describe how people organize colors, flora, kinship relationships, even life on skid row (see Spradley, 1972). Though there are limits to such methods, the investigator nevertheless acquires some insight into other constructions of reality.

I proceeded to analyze the data, employing sophisticated multivariate statistical procedures that enable one to determine patterns otherwise not observed easily. The results revealed a remarkable degree of consistency among individuals from the same group and significant variation across white, middle class patients, Native American patients, and psychiatric residents. Figures 1, 2, and 3 depict the cognitive maps that emerged.

Each box signifies a “pile”—cluster, grouping, or category—that was common to the individuals from a given setting who completed the task described above. The lines between the boxes similarly indicate relationships reported to exist between “piles.”

Before continuing, take out a piece of paper, write the numbers 1, 2, and 3, and indicate the group of individuals to which you believe each figure corresponds: white, middle class patients, American Indian patients, or psychiatric residents. Done?

Figure 1 represents the organizational schema that characterizes the responses by psychiatric residents; Figure 2 that of the American Indian patients; Figure 3 that of the white, middle-class patients. Surprised? Most people are.

Actually, many mental health professionals are able to guess correctly that Figure 1 recapitulates the psychiatric perspective. These five clusters or groupings mirror central themes of the DSM—referred to as diagnostic criteria—in regard to the
nature of mood and anxiety disorders. These included dysphoria or depressed affect, hyperarousal, self-focused attention (increased sensitivity to physiological cues), and cognitive distortion, especially heightened perceptions of threat. When questioned, the psychiatric residents unhesitantly referred to the DSM as the basis for their decisions about how they categorized the cards.

The American Indian patients (Figure 2) sorted the same words and/or phrases into eight quite different categories. There are some similarities to the young psychiatrists-in-training, notably with respect to feelings of sadness and despair. However, close inspection reveals that many signs and symptoms have been realigned with others in unanticipated ways. Moreover, one cluster (the one not connected to any of the other clusters) is seen as totally unrelated to any of the other clusters: a perspective without parallel among either the residents or white patients. One reason for such differences is the lack of similar emphasis in distinguishing between psyche and soma, which reflects a long Western intellectual history of mind-body dualism.

Perhaps the most counterintuitive results are those from the white, middle class patients (Figure 3). They perceived 15 separate groupings or clusters among the 100 cards. Clearly, these individuals more finely discriminated certain kinds of experiences, especially somatic or bodily sensations, from others.

You might have expected the cognitive map of American Indians to differ from their white, middle class counterparts and from psychiatrists. However, few of us probably would predict the divergence between the latter two, especially since they seem to share so much in terms of their respective cultural backgrounds. Yet, this is a very powerful example of how culture shapes the organization of the key signs and symptoms of an illness experience, in this case, depression and anxiety, which often are assumed to be universal in nature.

Here, there are three cultures at work: those specific to the families and communities of white
and American Indian patients and that of the biomedical tradition, in which the psychiatric residents, like children in the others, are acquiring a basic set of values, beliefs, logic, and language. Let me illustrate.

As all of us have, while growing up, I sometimes feigned being too sick to do a chore, go to school, or comply with some other expectation of me. I vividly remember times when my mother responded: “Well, you certainly don’t look sick,” and forced me to follow through with the obligation at hand.

This simple example suggests that we are subject to subtle, but profound socialization processes that deeply affect our perceptions, behavior, and attributions of meaning. Families, friends, and co-workers are the primary groups of socialization in most of our lives, and at different points in our lives. Hence, the psychiatric residents that I interviewed were applying lessons learned from their

“families” (fellow trainees and supervising clinicians) to make sense of the many words and phrases presented to them by their patients. These

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particular lessons are intended to communicate the basic elements of the cognitive map characteristic of psychiatry, as embodied in the DSM-III-R. Medical
anthropologists refer to such cognitive maps as "explanatory models" (Kleinman, 1988). Everyone possesses models for explaining illness and distress. As the responses to the sorting task described above suggest, these models are not necessarily the same from one group to another.

Explanatory models of illness not only organize the signs, symptoms, labels, or idioms that people employ to talk about matters like depression and anxiety, but also their beliefs about causation, associated psychological processes, precipitating situations, and treatment alternatives (Kleinman & Good, 1985). For example, from the biomedical perspective, disease is presumed to be a consequence of some maladaptation, maladjustment, or malfunction of human biology. Thus, psychiatrists speak of major depressive disorder as a biochemical imbalance, resulting from the interaction of psychic trauma and physiological mechanisms. However, among Catholic Pentecostalists, depression may be seen as God's retribution for moral transgression; for Haitian Blacks, it may follow from supernatural intervention.

Meaningful distinctions among the concepts of depression as a transient, everyday mood, as a symptom ("I feel depressed"), and as a disorder (major depressive episode) also are embodied in a culture's explanatory models. The DSM assumes that such experiences are unidimensional, linear, and additive in nature, not unlike a ruler. A combination of depressed affect (feeling sad, blue, or downhearted), cognitive impairment (inability to concentrate), physiological disturbance (trouble sleeping, fatigue, psychomotor agitation), and behavioral change (rapid weight gain or loss) lasting two weeks or longer defines major depression. However, the "markers" on a ruler may vary from one group to another akin to the difference between metric and non-metric systems of measurement. Not only may the scale of measurement differ in
backaches, exhaustion, and persistent distress may be a part of her day-to-day life. Likewise, a period of prolonged grief and mourning, lasting up to one year, in regard to the recent death of a loved one may be acceptable, indeed expected among older Hmong, with behavioral and dietary prescriptions as well as anniversary celebrations to commemorate the deceased.

Explanatory models also posit that certain situations expose an individual to pathogens or agents of illness. The DSM lists job loss, divorce, family conflict, and chronic illness as situations of vulnerability that contribute to risk of major depression. Among American Indians, ignoring important social obligations or failing to observe religious dictums may leave one open to potential harm. Among Punjabi Muslims, violating dietary restrictions or trespassing on sacred places invites divine interdiction.

Lastly, explanatory models typically encompass assumptions about available, relevant, and desirable methods for treating an illness. A psychiatrist often recommends antidepressants and cognitive-behavioral therapy to control the psychophysiologic symptoms of depression and to resolve emotional distress. White, middle-class Americans may try homeopathic as well as naturopathic medicines. Asian Americans typically view acupuncture and herbal treatments as appropriate; Christian fundamentalists may seek faith healing alternatives. Key people in these cultures serve as gatekeepers, validating symptom expression and directing the individual toward potential treatment resources. Different kinds of help-seeking behavior may be encouraged in terms of simultaneous or successive hierarchies of resort (e.g., seeking help from more than one source at the same time or from multiple sources one after the other).

This growing body of evidence in regard to cross-cultural variation in the content, form, and meaning of illnesses like major depression poses a significant challenge for present-day psychiatry. Maser, Kaelber, and Weise (1991) recently surveyed 146 mental health professionals, primarily psychiatrists and psychologists, from 42 countries as to international uses of and attitudes toward the DSM-III-R. Nearly a quarter of the respondents reported that the mood disorders are problematic and need revision. Maser et al. concluded by emphasizing the cross-cultural deficiencies of the DSM, and the need to address this broader range of experience in the nosology and diagnostic formulation.

There are no easy means available by which to accomplish this goal. Much more is required than tinkering with the kind, number, clustering, or duration of symptoms. The focus needs to be on the process of inquiry, the way in which a clinician elicits the respondent's story of his or her illness (Kleinman, 1988). This process should continue to emphasize the careful clinical description that led to the development of the DSM-III; however, in this case, that tradition now needs to be extended beyond the middle and upper classes of U.S. and European society to the remaining, non-Western world that constitutes the vast majority of human-kind. A better understanding of the phenomenology of mood disorders across these settings will have to encompass much more than simply the symptoms expressed by a patient. It must take into account the social contexts and cultural forces that shape one's everyday world and that give meaning to interpersonal relationships and life events.

REFERENCES