sion articulated principally as an intrapsychic experience (e.g., “I feel blue”), and even in the West most cases of depression are still lived and coping with as physical conditions (e.g., “my back aches”). The term applied to this phenomenon is somatisation: the expression of interpersonal and personal distress—e.g., frustration, despair, major depressive disorder—in an idiom of bodily complaints (Kleinman, 1986, 1988a). Kirmayer (1985) shows that whether somatization is a sociolinguistic or psychophysiological process, or both, remains unclear. The practical significance of somatization for cross-cultural studies of depression is that the models of depression based on studies of inpatients and outpatients in Western psychiatric settings tend to emphasize a picture of depression that is not the main one in non-Western societies (where the vast majority of the world’s population and most of the depressed live). In many societies and subcultures, rules of politeness, absence of psychological linguistic terms, expression of emotion in nonverbal modes or in formal aesthetic forms such as poetry, and understanding of depression as a bodily experience lead to symptom pictures that may include little or no psychologically minded expression of dysphoria.

For this reason, depression may not be diagnosed, and DSM-III and ICD-9 categories, if used in the strict sense without an appreciation for subtlety and metaphor, may lack validity in non-Western settings or among certain ethnic populations. The forms of somatization show local cultural patterns, with complaints (Kleinman, 1986, 1988a). Kirmayer (1985) shows that whether somatization is a sociolinguistic or psychophysiological process, or both, remains unclear. The practical significance of somatization for cross-cultural studies of depression is that the models of depression based on studies of inpatients and outpatients in Western psychiatric settings tend to emphasize a picture of depression that is not the main one in non-Western societies (where the vast majority of the world’s population and most of the depressed live). In many societies and subcultures, rules of politeness, absence of psychological linguistic terms, expression of emotion in nonverbal modes or in formal aesthetic forms such as poetry, and understanding of depression as a bodily experience lead to symptom pictures that may include little or no psychologically minded expression of dysphoria.

For this reason, depression may not be diagnosed, and DSM-III and ICD-9 categories, if used in the strict sense without an appreciation for subtlety and metaphor, may lack validity in non-Western settings or among certain ethnic populations. The forms of somatization show local cultural patterns, with neu­rasthenic patterns of complaint common in East and South Asia and becoming popular again in the West under the rubric of chronic fatigue syndrome. Heart distress in Iran (Good, 1977), dizziness in China (Kleinman, 1986; Otis, 1990), gastrointestinal complaints among Cambodian and Vietnamese refugees in North America, physical sensations of the loss of soul or vital essence in a number of societies (Sweder, 1985), are examples of local illness idioms, final common pathways that express distress and disorder of many types, including depression (see Carr & Vitaliano, 1985). Somatization in the non-Western world, moreover, is not infrequently associated with parasitic infections, anemia owing to malnutrition, and other intercurrent physiological pathologies so that the bodily idiom of distress has a ready-made physiological basis, and one that also contributes to the onset of depression. Indeed, this is also a significant problem for diagnosis (Weiss & Kleinman, 1987), inasmuch as the symptoms of many medical disorders (e.g., anorexia, sleep disturbance, reduced energy, motor retardation) overlap with the vegetative complaints of depression, rendering diagnosis uncertain.

Somatization may also shape the course and outcome of depressive disorder. Where somatization rates are highest, guilt, low self-esteem and suicide tend to be less frequent (see Kleinman’s 1988a review of this issue, pp. 42–45). On the other hand, somatization of major depressive disorder has routinely been found to delay effective treatment for depressive disorders and to contribute to minimal utilization of outpatient and in-patient services (Katon, Kleinman, & Rosen, 1982). Anecdotal reports from clinicians suggest that somatization of depression may “protect” depressed patients from morbid preoccupation with emotional states and thus reduces the likelihood of depression becoming a way of life. To the best of our knowledge this potentially significant proposition has never been investigated. We turn our attention now to cross-cultural examination of social factors and the onset of depression. Most prominent among these are gender, social class, family relations, refugee/migrant status, and social change.

### Gender and Depression

An overwhelming number of Western studies of depressive disorder report a significantly higher rate of depression among women than men (Blazer et al., 1985; Craig & Van Natta, 1979; Howell & Bayes, 1981; Redloff, 1985; Weissman & Myers, 1978). In a critical review of these studies, Weissman and Kleinman (1981) conclude that socially inculcated gender differences in susceptibility to depression are real, that is, not based on endocrinological or genetic factors, differences in helpseeking or affective expression, or methodological artifact. For Western societies, they cite the often-quoted evidence showing greater depression among married females (vs. married males) as illustrative of the conflicts generated by the traditional female role (1981:184). The classic study of Broverman et al. (1970) documents a strong gender differentiation in clinicians’ mental health ideals has frequently been cited as evidence of the inherent conflicts posed by sex-role stereotypes in the United States (Broverman et al., 1970, p. 322). For example, healthy women are said to differ from healthy men by being more submissive, less independent, more emotional, and so forth.

Recent epidemiological evidence from the multi-site NIMH Epidemiological Catchment Area (ECA) studies confirms gender differences in the prevalence of affective disorders within the United States. From the cities of Baltimore, New Haven, and St. Louis, Rother and associates (1984) reported differences most clearly predominated in men were antisocial personality and alcohol abuse. Disorders that most clearly predominated in women were depressive episodes and phobias. This finding was true of all three East Coast ECA sites.

Further evidence of female psychiatric vulnerability comes from the work of Brown and Harris (1978), who found that depression was extremely common among London working class women. In addition, they identified a set of specific vulnerability factors characteristic of the life circumstances of depressed women. These include lack of employment outside the home; absence of an intimate or confiding relationship with a husband/boyfriend; three or more small children in the home; and loss of mother prior to age eleven. Howell and Bayes (1981)
formulate a similar set of risk factors, including lack of outside employment, the presence of young children, being employed in addition to household and child-care responsibilities (resulting in fatigue), family moves that follow the husband’s employment and result in her own unemployment and/or social isolation. Indeed, “because of the particular constellation of environmental circumstances that rather universally characterizes married women in this culture, we are often to some extent diagnosing a situation rather than a person when we diagnose a woman as depressed” (Howell, 1981, pp. 154–155, italics in original).

Weissman and Kleinman (1981) report that “The evidence in support of these [gender] differential rates is best established in Western industrial societies. Further studies in non-Western countries . . . are necessary before any conclusions can be drawn as to the universality of this differential rate” (p. 184). Although much more research is needed to map out cultural dimensions of the role of gender in predisposing individuals to depression, these authors appear to have been unaware of a small but suggestive anthropological literature from which hypotheses can be drawn.

For Africa, the most important early work was conducted by M. J. Field. Based on her study of Ghanaians seeking help at healing shrines, she reported that “depression is the commonest mental illness of Akan rural women” (1960, p. 149). Women who have recourse to the healing shrines tend to be of an age at which they should be reaping the benefits and social prestige customarily accorded to senior wives, but in many cases their positions have been undermined by their husbands’ introduction of younger wives into the household. A common presenting complaint of these women is self-accusation of witchcraft. Among the Akan, witchcraft is a detested and highly stigmatized behavior; thus self-accusation indicates extremely low levels of self-esteem and self-worth.

Abbott and Klein (1979) also document depression as more common among rural Kikuyu women than men in Kenya, linking it with women’s low status and concomitant powerlessness. In this culture, residence is patrilocal, and land is predominantly owned and controlled by the patrilineage . . .

More recently, Mitchell and Abbott (1987) reported on the patterning of symptoms of depression and anxiety among Kikuyu secondary school students. The authors found significant gender differences in the responses revealing that females reported more depressive symptoms than males. While the extent of the gender differences in depression was not as great as in the earlier study by Abbott and Klein (1979), they are nonetheless consistent in showing a greater female preponderance of depression. This finding was also recently reported in Kenya by Ndetei and Vadher (1982). The observation that depression is an extremely common disorder among African women has been supported by Orley and Wing (1979), who found higher rates among Ugandan female villagers than among working class women in London. Orley and Wing documented depressive disorder among 14.3% of male Ugandan villages and 22.6% of female villagers.

Ulrich (1987) observed depression to be extremely common among Havik Brahmin women in a south Indian village. Ulrich argues that the traditional cultural ideal of women predisposes them to depression. Indeed, Beck’s triad of negative self-image, negative interpretation of life events, and negative view of the future is regarded as the cultural ideal for older women. Additional factors that may lead to depression among women in this setting include early marriage age (an associated loss of contact with close kin), poor marital relationships, and the perception of helplessness. With cultural changes and an increase in marriage age, educational level, and decision-making, however, it now appears that this cultural bias against women is no longer fully sanctioned in this contemporary Indian setting.

A striking age-related finding in the study by Karno and colleagues (1987) identifies the group most vulnerable to depression as young (18–39 years-of-age) non-Hispanic White women: over 15% of this subgroup had suffered major depression. Such age-specific vulnerabilities to depression have been noted elsewhere (Hirshfeld & Cross, 1982). These younger age cohort of Caucasian American women in the ECA study suffer disproportionately from major depression relative to men in either ethnic group or women of Mexican descent. These findings are particularly alarming, and as noted by the authors, require further explication. Such results sound a cautionary note against simplistic reasoning concerning presumed cumulative effects of ethnicity, socioeconomic status, and gender in the absence of sociodemographic data on age. The importance of age-specific data is further borne out by Karno and colleagues’ (1987) findings that dysthymia was most prevalent (9.4%) among older women (i.e., 40 years-of-age) of Mexican descent. Although the Puerto-Rican study did not provide age-specific data, dysthymia was also noted to be highly prevalent among women (7.6%) relative to men (1.6%) (Canino et al., in press-b).

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formulate a similar set of risk factors, including lack of outside employment, the presence of young children, being employed in addition to household and childcare duties, and concomitant powerlessness. In this culture, residence is patrilocal, and land is only to the home, the domestic space. Women are to defer to men, and family responsibility (1979, p. 164). Abbott and Klein find that the least labor in cities and towns, leaving women with the burden of horticultural labor. Although much more research is needed to map out cultural dimensions of the role of gender in predisposing individuals to depression, these authors appear to have been unaware of a small but suggestive anthropological literature from which hypotheses can be drawn.

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Abbott and Klein (1979) also document depression as more common among rural Kikuyu women than men in Kenya, linking it with women’s low status and concomitant powerlessness. In this culture, residence is patriarchal, and land is predominantly owned and controlled by the patrilineage. “Cultural beliefs and values regarding women generally devalue them, characterizing them as less intelligent than men, as rightly under the domination of men, and as belonging only to the home, the domestic space. Women are to defer to men” (1979, p. 181). In addition, two thirds of the men have left the community to seek wage labor in cities and towns, leaving women with the burden of horticultural labor and family responsibility (1979, p. 164). Abbott and Klein find that the least modernized women are at the greatest risk for depression, seeming to belie the common notion that modern urban life is more conducive to mental disorder than traditional rural life. However, we would suggest that in a region so much under the hegemonic sway of wage labor economy that two thirds of the men are absent, the self-definition of women may have been sociohistorically recast as “backward,” hence reinforcing their subordinate status.

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(1984) found that the types of severe life events associated with depression varied with the degree of integration into traditional society. As among African women (Abbott & Klein, 1979; Field, 1960), Hispanic women have been identified as a population at high risk for the development of depressive disorders (Menides de Leon, 1988; Richman, 1987; Torres-Matrullo, 1982; Vega et al., 1984; Zavalla, 1984). In the United States, this group has been considered particularly vulnerable by virtue of gender and ethnic minority status, and often, lower socioeconomic status as well (Mirande & Enríquez, 1979; Zavalla, 1984). From Los Angeles, a cross-cultural component of the Epidemiological Catchment Area survey (Karno et al., 1987) was designed to include Mexican-descent populations. Major depressive episodes showed:

- a surprising ethnicity effect among women, with non-Hispanic white women under 40 years of age showing 2.5 times the rate of Mexican-American women. These differences disappear in those over the age of 40. A strong trend is present for greater prevalence of total affective disorders on the part of young non-Hispanic white women compared with young Mexican-American women. Dysthymia shows a trend toward greater prevalence among Mexican women over ages 40 compared with their non-Hispanic white counterparts. (p. 699)

Recent lifetime prevalence data from epidemiological studies utilizing the Diagnostic Interview Schedule (DIS) confirm a gender vulnerability (Canino et al., in press-b; Karno et al., 1987). Among a Puerto Rican sample, Canino et al. (in press-b) found significantly higher depression and dysthymia among women. Gonzales (1978) found that Puerto Rican women who had been diagnosed as neurotic or depressive and were receiving treatment had sex-role orientations significantly more traditional than did comparison (normal healthy) housewives and students. Torres-Matrullo (1982) found a high incidence of symptoms of dependence among nonacculturated mainland Puerto Rican women. "Feelings of inferiority, low-self-esteem, psychosomatic complaints, and premature marriages and parenthood among Hispanic women have been regarded as resulting from the traditional female role" (Canino, 1982, p. 123). However, empirical research is necessary for a more sophisticated understanding of gender roles in Hispanic culture, since characterizations of women in the current literature are overly simplistic:

- It is questionable whether most functional Hispanic traditional women are as subjugated, passive, and dependent on the male as the literature depicts them to be. But the question still remains as to how can we explain the higher incidence of psychopathology found among traditional Hispanic women. Is it that the role per se induces psychopathology? Or is it that dysfunction occurs more often when the woman is in a societal and family context where the traditional role is not valued, but on the contrary, is maladaptive and conflictive? (Canino, 1982, p. 124)

In light of the foregoing cross-cultural studies, we can advance the hypothesis that epidemiological studies in the Third World will reveal a disparity between female and male rates of depression broadly similar to that documented in Western societies. This hypothesis is lent credence by the nearly universal structural subordination of women cross-culturally (Collier, 1987; Farnham, 1987; Lamphere, 1987; Rosaldo & Lamphere, 1974; Sanday, 1981). Nonetheless, overall rates are likely to vary for women relative to local factors such as child socialization practices, variations in control over resources, marriage patterns, and cultural ideology and value orientations surrounding gender relations. Moreover, there are exceptions. In one epidemiological survey. Carstairs and Kapur (1976) found a higher rate of depression among men than women in a rural region of southwestern India. However, in that matrilineal society there is considerable social dislocation due to newly legislated patrilineal inheritance patterns.

### SOCIOECONOMIC STATUS AND DEPRESSION

Hirschfield and Cross (1982) recently summarized the relationship of social class to depressive disorders in Western settings: "Whether defined by occupational, income, or educational level or a combination of these, there is strong evidence that rates of depressive symptoms are significantly higher in persons of lower SES than in persons of higher social class" (p. 39). Indeed, this association has been similarly reported by numerous investigators (e.g., Craig & Van Natta, 1979; Radloff, 1985; Weissman & Boyd, 1983). However, rates of unipolar depressive disorder have also been found to be exceptionally high among upper SES professional women (Welner, Marten, & Wochnick, 1977). Reviewing lifetime prevalence of depression in a community survey, Weissman & Myers (1978) similarly reported a vulnerability to depression among the upper social classes.

Studies of general psychiatric disability and unemployment have typically shown a strong relationship between economic conditions and admissions to treatment. Brenner (1973) conducted a survey of psychiatric hospitalizations in the United States between 1914 and 1967 to show that economic downturns were associated with increased rates of hospitalization. In an extensive review of research on schizophrenia and economic conditions, Warner (1985) cites evidence of the higher prevalence of schizophrenia found in lower social classes, except during times of full employment. He noted that outcomes, such as the degree of impairment in social functioning, are linked to the type of economic structures within social groups. During periods of unemployment in wage labor economies, for example, recovery is poor relative to patient outcomes within agrarian peasant societies. In light of current epidemiological data, similar hypotheses could also be advanced for depressive disorders.
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As noted before, in London, England, Brown and Harris (1978) found that working class women had a rate of depression four times higher than middle-class women. Working class women were likely to suffer a depressive episode in the year prior to research contact if they had certain vulnerability factors (e.g., lack of a close confiding relationship with a husband/boyfriend; unemployment) and had experienced a severe life event (e.g., death in the family). Findings such as these raise the obvious question of whether qualitatively different life conditions may engender vulnerability to depressive disorders, and thereby account for the association between SES and depression. Brown and Harris (1978) lay the groundwork for empirical investigation of this issue by elaborating research methods to document life events and life difficulties. They begin with the caveat that there is "... nothing to suggest there is any difference in the appraisal of adversity in the differing social classes in Camberwell... working-class women simply have more" (p. 191). (Similar observations about the cumulative and "objective" effects of oppressive life circumstances among the poor have been reported by other investigators [Hirschfeld & Cross 1982]). In addition, because their material conditions are more tenuous than their middle-class counterparts, they suffer more in response to loss or disappointment. Brown and Harris pinpoint the subgroup of lower SES women with children living at home as experiencing the greatest number of severe life events. Examples of such events include learning that a husband has cancer, losing a job at short notice, son killed while at play, evicted by landlord, being forced to have an unwanted abortion because of poor housing conditions, over­ close love relationship, and schoolage daughter. For chronic depressive conditions, the higher rates of depression for working class women hold across all life stages, and are not restricted to those with children living at home.

This work suggests that attention to adverse life events may contribute a valuable element of specificity to broad-based findings about social class and vulnerability to depression. Studies which have begun to follow this lead include a comparison of depressed and normal controls in Kenya that found significantly more life events among depressed patients in the 12 months preceding onset (Vadher & Nedetei, 1981). In an independent line of research Paykel (1978) has also documented the precipitation of clinical depression by stressful life events. Brown and his colleagues have continued to increase the specificity of the relation between particular types of severe life events and characteristics of women at risk (Brown, Bifulco, & Harris, 1987; for a methodological critique of Brown's earlier work see Tenenbaum & Bebbington, 1972). Consistent with the approach adopted by meaning-centered medical anthropology (Good & Good, 1982) is the finding that the most important aspect of life events is the meaning attributed to specific and cumulatively distressing life circumstances. Rather than the impact of change per se being deleterious to one's mental health, it is the personally incorporated cultural meanings of those events that appears to be of crucial importance (Brown, 1974; Brown & Harris, 1978; Day et al., 1987). Moreover, social supports have routinely been shown to be less available and more fragile for lower socioeconomic persons. Inasmuch as this feature of the social environment also predicts for depressive onset, comparative studies of the meaning of supports would seem to be another avenue for future cross-cultural research. From the anthropological standpoint, stressors and supports are systematically bound together within local social systems. These systems may protect individuals (and categories of individuals) from major social pressures or may render them particularly vulnerable to forces of deprivation, oppression, or loss (Kleinman, 1986), forces which can create local vicissitudes of demoralization and defeat. The anthropological perspective calls for a different methodology for measuring stress and support, one that takes into account the ethnographic description of the changing social contexts within which events are perceived, experienced, and managed.

Relatively scant attention, on the whole, has been allotted to the question of socioeconomic status and depression cross-culturally. This is in part due to the difficulty of obtaining valid indicators of social stratification and class variation, on the one hand, and the paucity of cross-cultural studies on depression, on the other. However, these studies consistently report that the least educated have higher depression scores (e.g., Abbott & Klein, 1979; Vega et al., 1984; Zawalla, 1984). Moreover, the other major component of social class, employment, is also linked to depressive illness (Dressler, 1986; Nedete & Vadher, 1982). Dressler and Badger (1986) found that among Blacks in the southern United States unemployment was significantly related to higher depressive symptomatology, independent of other demographic factors or stressful life circumstances. These findings support the general conclusion that unemployment engenders a substantial risk for the development of depression.

### DEPRESSION AMONG REFUGEES AND IMMIGRANTS

Recently, there has been a proliferation of studies of the relation between political exile and depressive disorders. Depressive illness is apparently quite common among Southeast Asian refugees (Beiser, 1985; DeLay & Faust, 1987). In a survey of 97 Hmong adult refugees in the U.S., Westermeyer (1988) found a very high rate of psychiatric and social disorder that included major depressive illness. A group that was found to be particularly vulnerable to depression was unmarried Laotian and Vietnamese refugees, who showed high levels of depression in the 1–12 months following their arrival. Other investigators have also found depression to be extremely common among Vietnamese refugees in primary clinic settings.

In an Indochinese clinic population in the United States, many of the patients had concurrent diagnoses of major affective disorders, posttraumatic stress disorder, and medical and social disabilities resultant from a history of trauma and
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Brown and Harris (1978) lay the groundwork for empirical investigation of this issue by elaborating research methods to document life events and life difficulties. They begin with the caveat that there is "...nothing to suggest there is any difference in the appraisal of adversity in the differing social classes in Camberwell...working-class women simply have more" (p. 191). (Similar observations about the cumulative and "objective" effects of oppressive life circumstances among the poor have been reported by other investigators [Hirschfeld & Cross 1982]. In addition, because their material conditions are more tenuous than the middle-class counterparts, they suffer more in response to loss or disappointment. Brown and Harris pinpoint the subgroup of lower SES women with children living at home as experiencing the greatest number of severe life events. Examples of such events include learning that a husband has cancer, losing a job at short notice, son killed while at play, evicted by landlord, being forced to have an unwanted abortion because of poor housing conditions, over­ dose taken by school-age daughter. For chronic depressive conditions, the higher rates of depression for working class women hold across all life stages, and are not restricted to those with children living at home.

This work suggests that attention to adverse life events may contribute a valuable element of specificity to broad-based findings about social class and vulnerability to depression. Studies which have begun to follow this lead include a comparison of depressed and normal controls in Kenya that found significantly more life events among depressed patients in the 12 months preceding onset (Vahder & Nedetei, 1981). In an independent line of research Paykel (1978) has also documented the precipitation of clinical depression by stressful life events. Brown and his colleagues have continued to increase the specificity of the relation between particular types of severe life events and characteristics of women at risk (Brown, Bifulco, & Harris, 1987; for a methodological critique of Brown’s earlier work see Tennant & Bebbington, 1979). Consistent with the approach adopted by meaning-centered medical anthropology (Good & Good, 1982) is the finding that the most important aspect of life events is the meaning attributed to specific and cumulatively distressing life circumstances. Rather than the impact of change per se being deleterious to one’s mental health, it is the personally incorporated cultural meanings of those events that appears to be of crucial importance (Brown, 1974; Brown & Harris, 1978; Day et al., 1987). Moreover, social supports have routinely been shown to be less available and more fragile for lower socioeconomic persons. Inasmuch as this feature of the social environment also predicts for depressive onset, comparative studies of the meaning of supports would seem to be another avenue for future cross-cultural research. From the anthropological standpoint, stressors and supports are systematically bound together within local social systems. These systems may protect individuals (and categories of individuals) from major social pressures or may render them particularly vulnerable to forces of deprivation, oppression, or loss (Kleinman, 1986), forces which can create local vicious cycles of demoralization and defeat. The anthropological perspective calls for a different methodology for measuring stress and support, one that takes into account the ethnographic description of the changing social contexts within which events are perceived, experienced, and managed.

Relatively scant attention, on the whole, has been allotted to the question of socioeconomic status and depression cross-culturally. This is in part due to the difficulty of obtaining valid indicators of social stratification and class variation, on the one hand, and the paucity of cross-cultural studies on depression, on the other. However, these studies consistently report that the least educated have higher depression scores (e.g., Abbott & Klein, 1979; Vega et al., 1984; Zavalla, 1984). Moreover, the other major component of social class, employment, is also linked to depressive illness (Dressler, 1986; Nedete & Vadher, 1982). Dressler and Badger (1986) found that among Blacks in the southern United States unemployment was significantly related to higher depressive symptomatology, independent of other demographic factors or stressful life circumstances. These findings support the general conclusion that unemployment engenders a substantial risk for the development of depression.

DEPRESSION AMONG REFUGEES AND IMMIGRANTS

Recently, there has been a proliferation of studies of the relation between political exile and depressive disorders. Depressive illness is apparently quite common among Southeast Asian refugees (Beiser, 1985; DeLay & Faust, 1987). In a survey of 97 Hmong adult refugees in the U.S., Westermeyer (1988) found a very high rate of psychiatric and social disorder that included major depressive illness. A group that was found to be particularly vulnerable to depression was unmarried Laotian and Vietnamese refugees, who showed high levels of depression in the 1–12 months following their arrival. Other investigators have also found depression to be extremely common among Vietnamese refugees in primary clinic settings.

In an Indochinese clinic population in the United States, many of the patients had concurrent diagnoses of major affective disorders, posttraumatic stress disorder, and medical and social disabilities resultant from a history of trauma and
torture (Mollica, Wyshak, & Lavelle, 1987, p. 1567). The most vulnerable subgroup identified by these investigators was unmarried women. These women, typically the victims of rape and torture in the natal countries, suffered the most severe psychiatric and social impairment.

A protective factor identified for Indochinese refugees in the U.S. is living arrangements with families of similar cultural background: refugees in these settings were found to be significantly less depressed and had better school performance than those who lived in foster homes with Caucasian families or in group homes. Beiser (1988) investigated the issue of whether resettlement in Canada is associated with an increased risk for depression among Southeast Asian refugees, and found that better mental health was enjoyed by refugees the longer they remained in Canada. Length of time after displacement was also found to be associated with decreased symptom levels in a study of Iranian immigrants to the United States (Good, Good, & Moradi, 1985).

In Africa, the prevalence of depressive symptomatology among Namibian refugees residing in a sub-Saharan host country was quite high (Shisana & Celentano, 1985). These authors also found that social support helped to alleviate the effects of chronic stress, as represented by the length of time in exile, but that depressive symptomatology was to be understood as directly associated with difficulties incurred by the problems posed by the stressors of adaptation and acculturation.

Vega et al. (1986) conducted a large survey of immigrant Mexican women in southern California. Using the Center for Epidemiological Studies Depression checklist (CES-D), they determined that there was an inverse association between CES-D scores and number of years in the United States. Depression has also been reported as extremely common among Mexican immigrants in Northern California, and has been linked to the difficulties associated with living conditions that include racism, unemployment, crowded and unsanitary living situations, and undocumented legal status (Ring & Munoz, 1987).

In a study of Iranian immigrants to the United States Good, Good, and Moradi (1985) document the interplay of cultural themes, sociopolitical events, and acculturation. They found that depressive symptomatology was to be understood as directly associated with difficulties incurred by the problems posed by the stressors of adaptation and acculturation.

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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 inhospitable 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 extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982). Eaton and Weil (1955) have linked family cohesiveness and extended networks, values orientations, and self-structures (Engelsman, 1982).
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In a study of Iranian immigrants to the United States Good, Good, and Moradi (1985) document the interplay of cultural themes, sociopolitical events, and depressive disorder. Iranians interpret and communicate depressive symptoms in relation to elements already thematized in Iranian culture: sadness and grief are essential qualities of life elaborated in Shi'ite religious culture and popular literature, insecurity and mistrust are common interpersonal themes especially with regard to interpersonal relations and marital fidelity; uncontrolled anger is a culturally marked and stigmatized sign of depression; and emotional "sensitivit" acquired through early childhood experience is a common personality self-attribute. The experience of depression consequent to political deracination is shaped by these four cultural themes.

A factor analytic study of psychiatric symptom levels assessed with the Brief Symptom Index (BSI) in a nonclinical population of Jewish Iranian women immigrants suggested the presence of a distinctly Iranian depressive syndrome, 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 Guatemal (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.

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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-