ORIGINAL REPORT

Rethinking Depression: An Ethnographic Study of the Experiences of Depression Among Chinese

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Relative to studies of patients in the West, little research has focused on the lived experiences of patients with mental illness in non-Western societies. The current understanding of the phenomenology of depression and other psychiatric disorders is almost entirely based on studies of Western populations. The objective of the present study was to examine the experiences of depressive disorders among contemporary Chinese in Guangzhou (Canton), China. A total of 40 patients who had significant depressive symptoms were recruited using quota sampling from the outpatient department of a regional mental health service. The depressive experiences of participants were examined by open-ended, in-depth, ethnographic interviews. The interviews were taped, transcribed, and translated. Content analysis was conducted on both the Chinese and English transcripts. A total of six categories of affective experiences were identified among the participants. Indigenous affective lexicons, embodied emotional experiences, implicit sadness, preverbal pain, distress of social disharmony, and centrality of sleeplessness were regularly observed among the informants. Our findings suggest that psychiatric textbooks and diagnostic systems do not cover the full range of depressive symptoms experienced among contemporary Chinese. More studies are needed to examine how depression is differentially experienced globally—a crucial step in making professional diagnosis, treatment, and research more broadly applicable across cultures. (HARV REV PSYCHIATRY 2007;15:1–8.)

Keywords: **China, culture, depression, ethnography, illness experience**

INTRODUCTION

It is generally acknowledged that the experiences and expressions of depression are shaped by local sociocultural norms.[1–3] A core group of depressive symptoms—dysphoria, negative cognition, psychomotor retardation, sleep disturbance, fatigue, and loss of energy—exists universally, but the experiences and expressions of depression are known to vary across cultures, and those variations are clinically significant.[4,5] For instance, even though we now know that functional somatic complaints associated with depression are as common in the West as they are in the non-Western world, specific bodily idioms of distress and somatic experiences—such as pain, dizziness, heaviness in the chest or head—communicate the emotional pain of depressed, non-Western patients.[6–9] Affective concepts may also be used differently in different cultures; for example, depression may not be separated from anxiety, fear, or anger.[2,10]

Unfortunately, our understandings of the non-Western phenomenology of depression remain sporadic, and ethnophenomenological studies of psychiatric disorders are far better known in anthropology than they are in psychiatry or psychology. As a result, our knowledge of the phenomenology of depression—as in the criteria used in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification of Diseases*

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(ICD)—is almost entirely derived from European and American societies, often without consideration of how the experience of depressive illness might vary in different parts of the world. The result is an unintentional, but potentially severe, clinical bias in diagnosis, treatment, and research on non-Western sufferers of depression, who make up approximately 90% of all depressed patients globally. But this focus on the West and the resulting omission are also inadequate scientifically in that the current classification fails to take into account the full range of depressive experiences. This process of globalizing the experience of the West would be regarded as faulty for biological understanding in other domains, such as the taxonomy of plants, animals, and viruses. For example, in biological taxonomy, a virus discovered in Africa or China would be given the same consideration as a virus discovered in Europe or the United States. In psychiatric nosology, however, symptoms unique to non-Western cultures are generally neglected.

In order to address this knowledge gap and to ensure that our understanding of depression at both local and global levels is adequate, two things are needed: to incorporate the relevant knowledge base in medical anthropology and cultural psychiatry/psychology into the psychiatric mainstream, and to engage in further in-depth studies of the phenomenology of depression in non-Western societies.

METHOD

Design

We examined the phenomenology of nonpsychotic depression with open-ended, in-depth, ethnographic interviews. Ethnography is the close study of a local world—a village, an urban neighborhood, an institution, a network, or a patient population. Ethnography places special emphasis on values, local language, conceptual categories, indigenous practices, and, above all, experiences and meanings.[11] In this ethnographic study, we adopted a Husserlian phenomenological approach that required us to avoid privileging our preexisting knowledge, such as the dominant nosological framework, in the process of investigation.[12] The process, commonly referred to as "bracketing out," enabled an in situ understanding of the depressive experiences in the local context and minimized undue bias from researchers' background and training. The study protocol was approved by the Clinical Ethics and Human Subject Protection Committees of the involved universities.

Sample

With informed consent, 40 patients with significant depressive symptoms were recruited at the outpatient department of the Guangzhou Institute of Mental Health, in Guangzhou (Canton), China. The institute was the first psychiatric institution established in China and is currently one of the largest in the country.[13] The hospital and its outpatient department provide care for people living in Guangdong province, including those in rural areas. We have not used a community sample in the present study because mental illnesses are heavily stigmatized in Chinese society; identifying and interviewing depressed people in the community neighborhood, especially a village, can cause great social harm (e.g., estrangement and discrimination) to the participants and their families. Unless an ethnographic study is part of a major psychiatric epidemiological survey—so that both depressed participants and nondepressed controls are interviewed—the identity of the depressed participants would be exposed. We also did not recruit subjects in a primary care setting because that mode of sampling would disproportionately select for depressed patients who presented with somatic symptoms.

We recruited consecutive outpatients with quota sampling to ensure balanced representation of informants of different age, gender, education, living (urban/rural), and length of psychiatric treatment. All patients who had significant depressive symptoms—as determined by local attending psychiatrists (using dimensional variables)—were eligible for the study. We did not provide the local psychiatrists with a schema or operational definition to define "significant depressive symptoms." Instead, we allowed them to determine what was significant and meaningful in the local world. We did not use any conventional diagnostic criteria (categorical variables) to select informants, because we aimed to examine depression that did not necessarily fall within Western nosological boundaries. We avoided using the clinical diagnosis of depression as the selection criterion because doing so would exclude "depression" that was not yet known to the existing classification systems (DSM, ICD, or the Chinese Clinical Classification of Mental Disorders [CCMD]).* Eligible informants were excluded only if they did not provide informed consent.

Procedure

The ethnographic interviews were conducted by the first author, a trilingual research psychiatrist trained in ethnography. The interviews were conducted at the outpatient clinic or at a place that reflected informant's local world, such as a home or eating place. The interview location was chosen

*The CCMD draws on the DSM and ICD, is not based on traditional Chinese medicine texts, but does include Chinese research and clinical experience.

by the patients. The interviews were semistructured and guided by a list of topical questions (e.g., "Can you describe what you were like when you were most unwell?" "When you were unwell, how were you different from what you were like normally?"). The interviews followed an iterative process whereby questions about topics and sometimes the topics themselves changed as the formulation of the meaning and experience of illness developed. The interviews lasted 1–2 hours and were audiotaped. Each informant was interviewed once. The interviews were conducted in Cantonese or, in the case of five informants, Mandarin (standard Chinese).

Data Analysis

All ethnographic interviews were transcribed in standard Chinese orthography and subsequently translated into English for content analysis. The data were analyzed and coded independently in Chinese and English by two investigators and a research assistant. The content analysis was conducted manually without software, with notes written at the margins of the transcripts. These notes enabled the categorization of the data into similar subject areas in a process called coding. An inductive process of coding the data was employed, and analytical categories were identified as they emerged from the transcribed data.[14,15]

Analysis also involved the identification of themes derived from the guiding questions, along with the new categories that emerged from the data. Data analysis was validated by comparing the results of the two independent coding activities in Chinese and English. Discrepancies were discussed and only consensual findings were reported. The trustworthiness of the data and analysis was also ascertained with professional peer reviews in research meetings and seminars.

RESULTS

Sample Characteristics

A total of 43 eligible patients were approached, 40 of whom (93%) consented to participate in the study. The three nonrespondents were in a hurry to leave the clinic for other engagements. The mean age of the informants was 46.8 years (range, 19–66; SD = 13.5), and 26 of the 40 informants were married. About 57.5% had 12 or more years of education. The mean duration of illness was 5.3 years (range, .08–22; SD = 7.0). We were able to recruit only two informants (5%) who lived in rural areas. The sociodemographic characteristics of the participants are summarized in the text box.

Social and Demographic Characteristics of Participants ($n = 40$)

	n (%)
Sex	
Male	12 (30)
Female	28 (70)
Living place	
Urban area	38 (95)
Rural area	2 (5)
Marital status	
Married	26 (65)
Separated/divorced	3 (7.5)
Widow(er)	3 (7.5)
Single	8 (20)
Education	
Illiterate	2 (5)
Primary	6 (15)
Junior high	9 (22.5)
Senior high	18 (45)
Tertiary	5 (12.5)
Occupation[a]	
Unskilled	1 (2.6)
Semiskilled	7 (17.9)
Skilled	23 (59.0)
Semiprofessional	4 (10.3)
Professional	2 (5.1)
Homemaker	2 (5.1)
	Mean (SD)
Age	46.8 (13.5)
Duration of illness (years)	5.3 (7.0)

[a]Occupational data was available for only 39 of the 40 participants.

Experiences and Expressions

Depressive symptoms described in contemporary Western textbooks and diagnostic systems (e.g., loss of interest/drive, loss of appetite and weight loss, early morning wakening, psychomotor retardation, impaired concentration, uselessness, hopelessness, and suicidal ideas) were reported by all informants. In addition, a constellation of indigenous experiences and expressions were identified, which could be grouped into six categories.

1. Indigenous affective lexicons. Local expressions were used to describe depressive experiences that are well recognized in psychiatry.† These expressions included *henmen* (very constricted or bored) or *menmenbule* (bored and unhappy) for loss of enjoyment, *sixiang hunluan* (thinking confused) or *tounao hunluan* (brain confused) for impaired concentration, *jingshen hencha* (vitality very poor) for poor energy and concentration, and *touzhang* (head swollen)/*toushi* (head

†Here and throughout this article, an effort has been made to retain the flavor and literal meaning of the original Chinese, with the consequence that some words, phrases, or sentences could not be rendered in idiomatic English.

hardened)/*naozhang* (brain swollen) for tension headache. For example:

> Then I was sick again. I didn't want to do anything. I felt vexed and bored [*fan men*].I lost interest in everything . . . I feel very painful [*xinku*] at my heart. Sometimes I would rather die. Then I don't have to suffer anymore . . . *Men* means I had lost interest in everything. I just feel very *men*. I just want to sleep all the time. [case 3]

2. Embodied emotional experiences. Some expressions combined affective distress with bodily experiences. The compound terms nearly always involved the heart—*xinhuang* (heart panic), *xinjing* (heart dread/frightened), *xinfan* (heart vexed), *xintong* (heart pain), and *xinyi* (heart dysphoric/depressed/clutched/compressed). Some informants were adamant that emotional distress could be felt right inside or over the heart. Other compound terms showed that *xin* (heart) could be both the anatomical heart and the metaphysical mind, as *xinxing* (heart wakeful) and *xinlei* (heart exhausted) indicated. It has been suggested that "heart-mind" is the best formulation of *xin* as an embodied term.

> I felt my head swelling, very distressed and painful in the heart [*xin hen xinku*], my heart felt pressed . . . So . . . [sighing] . . . I felt my heart very irritated [*xin hen fan*], very upset . . . I felt my heart clutched and dysphoric [*xinyi*] . . . My brain swollen, so swollen inside. It is heart pressed and brain swollen [*xinyi naozhang*]. [case 29]

3. Distress of social disharmony. The distress of social disharmony was communicated through expressions such as *wenzeng* (irritable), *fanzao* (vexed and shaken), *piqicha* (poor tempered), *fapiqi* (irascible or bad tempered), and *rongyiku*/*rongyihan* (tearful). These symptoms are not unknown to psychiatrists, but they are generally not regarded as clinically or diagnostically important. Our informants, however, regarded these experiences as most distressing since they disrupted the social harmony within the family, workplace, or other social situations. Moreover, these terms are sociosomatic inasmuch as the core metaphors are physical—for example, *huo qi da* (hot tempered)—whereas their implications are interpersonal or social.

> It seems everything is not smooth, and I want to vent my anger toward them. I want to wreak terrible vengeance toward others although they haven't done anything wrong to me. If they don't realize that I am suffering from depression, it will lead to quarrels. I will be misunderstood. They will think I am mischief-making. Actually, I always feel unhappy because of these . . . [case 4]

4. Preverbal pain. We found that not all depressive experiences could be put into words. Some informants reported that they were extremely distressed but found it hard to articulate their psychological pain. Some would use terms such as *xinku* (hardship), *tongku* (painful suffering), or *nanshou* (tough experience/unpleasant) to approximate the preverbal distress. Some informants talked of the indescribable preverbal pain that preceded or led to their suicidal ideas, impulses, or even acts—for example, *nanshoudao shengburusi*, "so unpleasant that to die is better than to live on."

> That's unbearable [*hen nanshou*]. My eyes are tired but my brain is active . . . I am most worried that I can't bear the pain anymore and [will] decide to end my life. When I can't bear it anymore, and if I don't have any sleeping pills, then what can I do? That [emotional] pain is so unbearable. Very painful! Very painful! [*hen xinku! hen xinku!*] [case 1]

5. Implicit sadness. We found that sadness and depressed mood were often conveyed implicitly in the interview. Informants talked about their sleeplessness, weight loss, heart panic, head swelling, life difficulties, and social adversities in such as way that they expressed deep sadness without using the words for sadness. They would not directly report low mood, even after 60–90 minutes of interview. Some informants even appeared surprised when the interviewer inquired if they were depressed. They opined that, given their social predicaments, sadness or depressed mood was so natural, obvious, and inevitable that it was assumed to be understood.

> *Interviewer:* You have mentioned being stressed, not wanting to continue your life, but you have not mentioned being unhappy?
>
> *Informant:* Of course, I am unhappy! When I think of the troubles, even a fleeting thought, I would feel unhappy, I am unhappy most days. [The patient-informant expressed surprise at the question.] [case 1]

6. Centrality of sleeplessness. Some informants believed that the origin of their symptoms and problems lay in sleeplessness. These informants acknowledged that they were sad or depressed, but they were also adamant that the mood problem was only secondary to their insomnia. They strongly believed that their recovery hinged on the reversal of insomnia. For them, insomnia was the disease, depression only one of the symptoms.

> I suffered so hard [*xinku*] [to help the team at work], yet when I was not in fit condition, they kicked me out . . . So I was very unhappy and kept thinking about this, feeling very troubled, lost my sleep and

> couldn't sleep well . . . My friend advised me to come here for treatment. My condition improved after a period of consultation. I could sleep well and became better. So I stopped treatment, thinking that I had recovered. [case 29]

As the narratives of case 1 and case 29 illustrated, different categories of depressive experiences were transposed and juxtaposed within the same interview.

DISCUSSION

Our findings show that depressive symptoms recognized by contemporary Euro-American psychiatry are generally applicable to the Chinese. That is hardly surprising, given that the CCMD and the DSM/ICD diagnostic systems share similar symptom criteria for depressive disorders.[16] What is interesting about the findings, however, are the points at which the Chinese and Western depressive experiences and expressions diverge.

The Embodied Language of Depression

In anthropology and linguistics, it has long been recognized that human emotions are more than feelings and thoughts. Bodily events and processes regularly enter into the semantics and pragmatics of how languages encode ideas about emotions.[17] Rosaldo[10] succinctly described emotions as "embodied thoughts" that are somehow "felt" in flushes, pulses, "movements" of the liver, mind, heart, stomach, skin. Kuriyama,[18] in comparing how the human body was publicly perceived and subjectively experienced in Greek versus Chinese medicine, argued that there were different ways that experiences are embodied in Chinese and in European cultures.

We identified a collection of embodied expressions used by our informants to articulate and locate their experience of distress. In contrast to conventional somatic symptoms of depression (e.g., neck pain, back pain), these expressions describe distresses that combine psychological and bodily experiences (e.g., *xinhuang* [heart panic]). Hence, rather than being free-floating, the panic and fearfulness are experienced right in the heart. By joining body parts with affective lexicons, these compound terms encode the rich and fused distress of depression.

We found that the heart was the most common body part in which affective distresses are embodied. In Chinese, the heart's being regarded as the seat or container of emotions is manifested linguistically in an extremely rich fashion. Yu[19] identified 60 expressions of emotions—ranging over anger, anxiety, disgust, distress, fear, grief, guilt, happiness, and vexation—that invoke the image of heart. For instance, the Chinese term for happiness (開心) literally means "opened heart."

The close affiliation of heart and emotions is also seen in the construction of Chinese characters. In contrast to Western lexicons, Chinese characters are made up of elementary symbols, which recombine among themselves to create characters of richer and deeper metaphoric meanings. Thus, the character of sadness and grief (*bei*, 悲) is the character of heart (*xin*, 心) and the character of wrong/contradicted (*fei*, 非) combined. There are more than 100 Chinese lexical constructions of emotions that contain the figure of heart in combination with other symbols. These regular fusions of body and emotion in Chinese language suggest that the embodiment of Chinese affective distress has a deep and strong cultural structure in language and socialization.

Embodied emotional expressions are often casually labeled as metaphorical, idioms of distress, or somatization. None of these three labels, however, captures the core of the experiences. Metaphors and idioms are figurative, implying the experiences are either not literally genuine or that meaning predominates over lived experience. To the sufferers, experiencing fearfulness over their hearts or a swelling sensation in their heads is as real and as true as any other symptoms of depression. Likewise, somatization—the theory that the ego converts unexpressed emotions into bodily experiences—is an equally inadequate construct inasmuch as it artificially separates bodily and psychological symptoms that patients experience as a unified whole.[20] The Chinese experience of depression suggests that the existential core of depression is bodily.[21–23]

Depression Latent, Prelingual, and Inexpressible

In sharp contrast to the somato-emotional experiences that were actively reported, we found that sadness and depressed mood were often communicated and understood contextually without explicit verbal articulation. Chinese patients' unspoken communication of depressed mood could result from their construing "depression" differently than psychiatrists. The former are more concerned about the life difficulties and the pragmatics, whereas the latter are trained to elicit mood symptoms and create a diagnosis. It is also possible that some individuals lack or are unfamiliar with affective vocabularies for depressed mood—which may be especially common among those who have little education. We also recognize that context is crucial: Chinese who complain of the body in the clinic will talk more directly of feelings at home with family members.[24]

Human language is far from ideal in representing the self through ordinary terms.[25,26] Until the necessary vocabularies are invented, some private emotional experiences will remain prelinguistic and indescribable.[27] Preverbal pain is more than merely a Chinese transcultural observation. The late William Styron, a Nobel laureate in Literature,

recounted his personal experience of clinical depression as follows:

> I was feeling in my mind a sensation close to, but indescribably different from, actual pain. This leads me to touch again on the elusive nature of such distress . . . William James, who battled depression for many years, gave up the search for an adequate portrayal, implying its near-impossibility when he wrote in *The Varieties of Religious Experience:* 'It is a positive and active anguish, a sort of psychical neuralgia wholly unknown to normal life.'[27]

If two wordsmiths could have difficulties in describing fully and accurately their depressive experience, one can hardly expect common folk to fare better. It is, thus, legitimate to ask if contemporary psychiatry, whether East or West, has paid enough attention in research and clinical care to the limits of language and the preverbal quality of depression as severe pain.

Depression: A Qi, Mood, or Sleep Disorder?

In current-day traditional Chinese medicine practice, depression is conceptualized as a disorder of *qi* (the life force that flows around and through the body). In traditional Chinese medical texts, depression is called *yuzheng*, which literally means a stagnation disorder. Within this model, depression is caused by *qi* stagnating in liver, spleen, and lung, and recovery is brought about by dispersing the stagnation of *qi* with herbal medicines or acupuncture. Though mood disturbances are recognized symptoms in a variety of medical conditions, including *yuzheng*, there is not a concept of mood disorder per se in traditional Chinese medicine. As in many non-Western cultures, the concept of nonpsychotic depression is not indigenous among ordinary Chinese.

The centrality of sleeplessness in our informants' narratives is in sharp contrast to the *qi* and mood conceptualizations of depression. Further investigation is required to determine whether the sleep conceptualization of depression among contemporary Chinese represents a carryover of the neurasthenia tradition,[28] an attempt to stay away from highly stigmatizing psychiatric categories, or a product of the genuine centrality of sleeplessness in the entire illness experience (in China).

In any case, the current biomedical translation for depression—*yiyu zheng*—is far from ideal. The character *yu* (鬱) is a difficult word with 29 strokes (only 15 Chinese characters have more than 29 strokes). Even the simplified form of *yu* (郁) with 9 strokes is rarely used in daily writing. More importantly, although the Chinese term of *yiyu zheng* is regularly employed in medical settings, it is not in common use.[1] The informants of the present study were all aware of their diagnosis, but the term *yiyu zheng* carried little meaning for them. This divergence between popular and professional discourses needs urgent attention in order to improve communication between professionals and laypersons. An improved translation is needed to encompass the historical discourse, professional conceptualization, and, above all, the local understanding of what depression and morbid sadness are about.

Methodological Issues

Our study has several limitations. First, there were only 40 informants. The objective of qualitative studies is primarily to exhaust new themes rather than to test hypotheses. Thus, qualitative researchers rely on data saturation to judge sample adequacy;[14] it is customary to stop recruitment when further informants are expected to add no new themes or findings. It is of note that the sample was comparable to the average size of conventional ethnographies and that our data reached saturation at the end of the study (the last eight interviews added no new themes to the analysis). Nonetheless, further studies using quantitative methods are needed to ascertain the prevalence of the identified experiences among Chinese people with depression.

Second, the informants were selected from a clinical population rather than general community. Informants' previous contacts with mental health care professionals could have shaped how they presented their illness. Their willingness to seek help with psychiatric services might also mean that they were more ready to subscribe to the biomedical model and language of depression. Notwithstanding these biases, we were still able to identify a variety of phenomenological expressions of depression that could not have been shaped by clinical exposure. It was actually surprising how informants continued to express their distress in their own local idioms despite repeated medical encounters. Nonetheless, had we recruited a community sample, we may have found even less correspondence with familiar Western symptoms and may have found even more local and culturally particular manifestations of depression. Therefore, it would be worthwhile to repeat the study in a treatment-naive sample if arrangements could be made to preclude stigmatization of the participants.

Third, in reporting identified expressions and experiences, we refrained from citing the rates of occurrence. Since the study sample was not recruited for epidemiological purposes, any reference to rates of occurrence could be misleading. Instead, all reported themes were observed in at least a third of the sample.

Since few informants lived in lower-income rural areas, further studies are needed before findings can be generalized to the rural population. Finally, although the study sampled both Mandarin-and Cantonese-speaking informants, most spoke Cantonese. More than 70 million Mainland Chinese

speak Cantonese, which is also dominant among overseas Chinese populations, but replication studies in other parts of China are needed to affirm the findings in other linguistic contexts and to establish local differences.

Clinical and Research Implications

In many cultures, bodily experiences are regularly coupled with the expression of emotional distress. Depressive emotions are encoded and inscribed not only in feelings and thoughts, but also in bodily experiences and social contexts. Hence, patients may articulate their depression with embodied affective experience or communicate their distress through contextualized socio-moral experiences—as, for example, when references to the "face" are used in talking about the loss of moral status and social shame. Embodied emotions have been described in diverse cultures, from "the heart is not at rest" in Yoruba, "painful heavy heart" in Zimbabwe, "sorrow in the heart" in India, to "heavy heart" or "my heart sinks" in Anglo-American societies.[29,30] They are universal though their content and expression are culturally shaped.

"Bodily complaints" are therefore not best thought of as figurative or disguised symptoms. Rather they are bona fide experiences, as true as any other symptoms of depression, that deserve the same level of recognition and attention. Instead of regarding embodied symptoms, such as head swelling or chest pain, as atypical, metaphorical, or rudimentary, clinicians should view these expressions as windows that cast light on the deep sensibilities, personal and cultural, of being depressed. The failure to respect embodied affect can lead to therapeutic non-engagement. The failure of conventional diagnostic instruments to detect and capture embodied affective experience, as well as other ethnocultural expressions of depression, may explain the unusually low prevalence of depression reported in lay interviewer–administered epidemiological surveys among urban Chinese and in other societies.

We would like to emphasize that we are not presenting a critique of the DSM per se, but rather of psychiatry in general. We want to point out that contemporary psychiatric knowledge—as captured in the textbooks and diagnostic criteria—more accurately depicts depression in the West than in China. This result is unsurprising, given that the criteria and textbooks are based on Western patients. Nonetheless, we hope that the readers are aware that the phenomenology of depression is different in China and doubtless other non-Western societies. Hence, psychiatrists and researchers working with non-Western patients need to ask different questions in order to elicit the depressive symptoms and illness experience.

We hope that this study will stimulate more research on the phenomenology of depression and other psychiatric disorders. While existing diagnostic systems have tried to be culturally sensitive and appropriate, transcultural understanding has thus far stopped short—at the syndromal level. Little is known as to how psychopathology is experienced and articulated differently across cultures. Our findings also challenge some fundamental assumptions of the existing diagnostic symptoms, such as mind-body dualism[31] and the complete representation of psychological experiences via linguistic terms.[25] If the next edition of the DSM and ICD are to be transcultural, it is time to enrich our understanding of depression with a "deeper phenomenology" of sociocultural experiences[32] that integrates psychiatry, anthropology, and linguistics around local cultural studies.

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