

Critical phenomenology of depression in Brazil, Chile and the United States

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This study aims to understand the meaning of the lived experience of depression in Brazil, Chile, and the United States, focusing on possible cultural variations that could contribute to its cross-cultural understanding. Between 2001 and 2004, 72 adults with either depression or with clinical records of depression (n=30 in Fortaleza, n=22 in Santiago, n= 20 in Boston) had been submitted to phenomenological interviews which investigated the description of the depression lived experience. The results show that, though there is no variation in a symptomatology among the three countries, the lived experience associated with these symptoms varies according to different cultural subjective processes that are characteristic of each culture. In conclusion, contemporary lifestyles, along with some cultural changes, including economic and psychosocial oppression, contribute to the appearance and maintenance of depression.

Key-word: depression, critical phenomenology, cross-cultural.

Introduction

Depression has become “a trend illness” in the western world and has reached epidemic levels. We are now living the “depression era” (Batzán, 1994; Berlinck, 2000; Dawson & Tylee, 2001; Ehrenberger, 2000; Healy, 1997 and 2001; Lima, 1999; Moreira, 2002; Schumaker, 2001; Shorter, 2001). Historically, there is an enormous coincidence between the increasing number of depression diagnoses and the psychopharmacological development of drugs to treat this illness in the last 50 years. The introduction of the first generation of tricyclic anti-depressives in the 1950s has contributed to the recognition of depression as an illness. Likewise, after the introduction of benzodiazepines in the 1960s, the diagnosis of anxiety became predominant for the two ensuing decades. Given only what is diagnosed is treatable, and with the discovery of the SSRIs – anti-depressive inhibitors of serotonin reuptake – one could claim that there was a second decisive impulse in the diagnosis of depression in the 1980s (Shorter, 2001). Developments in the field of epidemiology and related developments in the diagnosis of mental disorders may also have contributed to the noted changes in rates of depression.

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The extent which depression actually takes place, and how many of these diagnoses relate to sadness and psychological suffering remains a question. Depression will always include sadness and psychological suffering, although the opposite is not true: a sad person or someone who suffers psychologically does not necessarily have depression. In the light of phenomenological psychopathology, suffering is ontological and therefore inherent to the being (Minkowski, 2000). On one hand, the prescription of serotonergics to treat sadness and psychic suffering confuses the current state of things because it collaborates with the biomedical imperialism that turns all human problems into a disease (Castro, Heimburger & Langer, 2002; Dworkin, 2001; Good, Brodwin, Good & Kleinman, 1992; Good, 1994 and 1997; Kleinman, 1988 and 1995; Kleinman & Cohen, 2001; Kleinman & Good, 1985; Shorter, 2001, Moreira & Freire, 2003). On the other hand, while the incidence of bipolar psychosis and severe melancholy actually has not increased recently, one could reasonably argue that depression misrepresents syndromes previously diagnosed as anxiety or neurotic disorders (Healy, 1997 e 2001). In any case, it is ironic that the depression epidemic grows with the discovery of increasingly effective treatments (Shorter, 2001). Moreover, the levels of disability associated with depression are higher than all other chronic diseases, such as hypertension, diabetes, arthritis, or back pain (Üstun & Chatterji, 2001).

Depression is nowadays the most common form of mental illness (Cox, 2001; Dawson & Tylee, 2001; Lima, 1999). The World Health Organization (WHO, 1999) identifies depression as being responsible for 10% of disorders and the most responsible for 4.2% of the disorders measured by *Disability Adjusted Life Years*. (DALYs). Depression is the fifth biggest handicap (Kleinman & Cohen, 2001). It is responsible for the loss of 10% of the world population's labor productivity and the main cost for the health care plan system. Even worse, the most severe forms of depression lead to suicide, a global problem that is responsible for practically 15% of deaths in Europe in the age demographic of 15-25 years (Aswall, 2001). It causes approximately 30,000 deaths in the United States and almost 1 million all over the world each year (Goldsmith, Pellman, Kleinman & Bunney, 2002). Given this alarming situation, the research on depression has increased enormously, generating the publication of articles in scientific journals, magazines, newspapers and other popular channels of communication. Nonetheless, there are few qualitative scientific studies focusing on trying to understand the human experience of depression while reflecting on the individual's social and cultural roots. Therefore, a comprehensive description of the process of falling ill by the depressive patients themselves could clarify the confusion between affect and illness.

A critical approach to the meaning of depression in the contemporary world is necessary; a methodology that looks into political and historical complexity, considering depression as a product of the singular cultural context from where it emerges (Fox and Prilleltensky, 1997; Prilleltensky, 2001). Understanding the anthropological significance of culture, as an intersection between meaning and experience (Kleinman and Good, 1985), leads us to think that the depressive experience will also have related ideological and cultural meanings. Consequently, depression, as well as other psychopathological disorders, needs to be studied as a cultural experience, emerging from not only the structural and the clinical processes, but also from social and political factors: "Data from the developing world demonstrates the need to consider the social roots of depression" (Kleinman & Cohen, 2001, p.12). That is, depression is not an illness whose etiology is purely individual (Moreira, 2002). Many of the symptoms explained as existential, medical, or psychological often have socialcultural origins, as shown by cross-cultural studies in psychopathology (Aboud, 1998; Draguns, 1990; Kim, Li & Kim, 1999; Kleinman, 1986; Kleinman & Good, 1985; Marsella, 1993 and 1998; Marsella & Yamada, 2000; Matsumoto, 1997; Moreira, 2000; Morris, 1998; Sartorius, 1993; Schumaker, 1996; Schumaker, 2001; Tatossian, 1997; Marsella, 2003; Moreira & Boris, 2006, Moreira & Callou, 2006).

In previous studies that involved theoretical and empirical research, I criticized anthropocentric humanism as part of an individualistic ideology in psychopathology. Grounded on Merleau-Ponty's phenomenology, I proposed a "worldly" understanding for psychopathology (Moreira, 1998, 2000, 2001 and 2002). In this perspective, I understand the human being in a worldly way, defined through "multiple contours", which interweave and mutually constitute themselves as expressed by Merleau-Ponty (1960) through Cézanne's painting. Therefore, I understand psychopathology not only as a field of study, but as the experience of mental pathology, necessarily including its cultural dimension, as well as the endogenous and situational dimensions that exist in mutual constitution (Moreira, 2002; Sam & Moreira, 2002). Applying this perspective, depression exists in the intersection between man and the world. Its etiology is anthropological, sociological, and political, as well as biological and psychological.

Assuming that psychopathology, which includes depression, manifests itself in mutual constitution with the world and its multiple contours (Moreira 2001 e 2002), the clinical phenomenology of depression would undergo transcultural variations with different ideologies attached to its cultural production. In view of this hypothesis, what is the current meaning of depression as a psychopathological manifestation, investigating Brazilian, Chilean, and North American cultures as seen from a *worldly* perspective? Are there differences in depression experienced by subjects in Brazil, Chile, or in the United States? Can these cultures critically understand the manifestation of depression and how it relates to cultural peculiarities? What is the ideological and cultural meaning of depression in the contemporary world?

Methodology

The methodology considered the population of patients diagnosed with depression or with a history of depression in Brazil, Chile, and in the United States. The complete sample of this cross-cultural research consisted of 72 adults (n = 30 in Brazil, n = 22 in Chile, and n = 20 in the United States). Each sub-sample was made of both female and male subjects. It was not possible to maintain the desired percentage of 50% between men and women. A great majority of collaborating subjects were women, corroborating with the literature to point that the incidence of depression is two to three times more frequent in women than in men (Dawson & Tylee, 2001; Healy, 1997 and 2001; Kleinman e Cohen 2001, Kleinman & Good, 1985, Lima, 1999; Moreira, 2002; Shorter, 2001, Stoppard & McMullen, 2003; among many others). In the North American sub-sample, there

were more men than women as collaborating subjects, which does not necessarily contradict the literature. The sample did was not intended to be a representative sample. It is compatible with conventional qualitative methodology (Creswel, 1998; Fisher, 1989; Forghieri, 1993; Giorgi, 1985, 1997; Gomes, 1998; Gonzalez, 1997; Guba & Lincon, 1985; Moreira, 2004; Moustakas, 1994; Ratner, 1997). In 2001 and 2002, 23 women and 7 men underwent interviews in Fortaleza, Brazil. The *Núcleo de atendimento Psicológico (NUSPA)* in the Universidade de Fortaleza (UNIFOR), and in the *Centro de Atendimento Psicossocial (CAPS)* in Fortaleza recruited the participants. Likewise, 16 women and 6 men were interviewed in Santiago, Chile, during 2002. CAP – *Centro de Atención Psicológica* of the Universidad de Santiago De Chile enlisted these participants. Scholarship research assistants trained at the Universidade de Fortaleza and at the Universidad de Santiago de Chile, respectively, conducted the interviews. In the United States, the main researcher administered the 20 interviews (8 women and 12 men) at the *Center House* in Boston in 2003.

The inclusion criteria for participation were the individuals' self-report of a diagnosis of depression, including both those who currently have or had a history of depression. The subjects had to be current natives and residents of Brazil, Chile, or the United States as well as adults between 25 and 55 years old. In addition, the study required at least a middle school education. The individuals were required to decide about their participation in this study and to provide the researcher with a written statement of their willingness to participate. The study excluded patients or former patients not wishing to participate and those incapable of making their own decisions. This methodology of identifying people with depression based on their self-report aimed to focus on the lived experience of people who considered themselves depressed, regardless of the definition.

The lead question of this interview using the phenomenological model of research was, *What relations do you find between your way of living and your depression?* The interviews were transcribed respectively into Portuguese, Spanish, and English, and are limited to 30 - 60 minutes. The data analysis was based on Giorgi's model (1985; 1997) and was adapted by Moreira (2004). The process follows as: a) Transcription of the interview, b) Division of the original text (literal transcription of the interview) into sections according to the "tone" of the interview (Moreira, 2001), c) Descriptive analysis of the meanings that emerged from each section, and d) "Coming out of brackets." The focus of the analysis in this fourth step goes back to the hypothesis (in phenomenological terms, "putting into brackets" means that the hypothesis would be forgotten during the first steps so that the researcher would be open and attentive to all contents that emerge – the phenomenon – and not only to what he is looking for).

Particular attention was given to the respondents' descriptions of their routine relating to their depression. Interviews were transcribed into Portuguese in Brazil, into Spanish in Chile for phenomenological analysis, using this data analysis model.

This study employed the phenomenological method to make sense of the meaning of the depressive experience. It allowed for the access to the phenomenon in itself, previously diagnosed as depression, in the perspective of who had lived or who is living this experience. The diagnosis was 'put into parenthesis' so that the experience itself could be studied, regardless of how this illness is regarded or pre-categorized. The meaning of this psychopathological disorder was sought through the identification of possible manifestations linked to each particular social and cultural context.

Results and Discussion

The lived experience of depression is associated to the following descriptive categories:

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1) Descriptions of Symptoms

... chorava assim por qualquer coisa, ficava sem comer, passava semanas sem comer. Ficava o tempo todo pensam do em me matar e em morrer."¹

Yo encuentro que la depresión... es cuando uno... (Titubea) no le dan ganas de vivir, no tiene deseos de hacer nada, todo lo mira igual."²

I didn't wanna get up in the morning. Life was not worth living, I wanted to commit suicide. I get up *and think: that's useless, I don't wanna* do this...

There are no significant transcultural differences related to the symptomatology of depression, yet there are transcultural differences regarding the experience associated with this symptomatology. That is, what varies in the narratives involves the factors or life situations that the collaborating subjects related these symptoms to, as we will see shortly. The description of the

1. "... I used to cry for any reason, I would not eat, would spend weeks without eating. I would spend the whole time thinking of killing myself, thinking of dying."

2. "I think that depression... is when one... (Titubea) doesn't want to live, doesn't want to do anything, everything looks the same..."

symptoms are, however, very similar not only in Fortaleza and in Santiago, but in Boston. All patients refer to the classic symptomatology of depression: discouragement, distress, lack of meaning in life, emptiness, lack of personal hygiene, insomnia, acute sadness, lack of confidence, a desire of 'hiding from the world', low self-esteem, pessimism, a longing for death, and suicidal attempts.

There is a massive allusion to the symptoms in the interviews. The collaborating subjects complained much about these symptoms. Even when they talk about other themes, they always turn back to the symptoms, which appear to have inhabited (in case depression was in the past) or are currently occupying a central place in these individuals' lives.

2) *Loneliness*

É essa tristeza, eu não sei dizer porque não. É uma tristeza que você tem, que não tem porque, porque graças a Deus eu sou bem casada e adoro a minha filha, e não tenho dívidas, mas é uma solidão, uma tristeza... meu negócio é ficar em casa sozinha, preferencialmente deitada e me isolando de tudo.³

No sé, me encuentro mal porque me encuentro sola...Eh, ¡claro! El sentirme sola me deprime.⁴

Lonely...brings me to be depressed. Just, just, being alone in Holidays, that's it. It kills me,...makes, and makes me depressed.

Regardless of the culture, loneliness appears in the narrative of the collaborating subjects in the three countries, although in Santiago and Boston, this issue comes up more often. In Santiago, the allusion to loneliness comes from homemakers who are isolated most of the day. In Boston, loneliness occurs because most of the interviewed subjects live alone, away from their family. In the United States, it seems like living on one's own is a more common practice than it is in Chile, a more gregarious Latin-American society. However, even in Brazil, which is supposed to be a culture of greatest social gathering, loneliness is part of the informants' experience of depression. This possibly relates to the increasing demand for individuals to work longer hours to maintain their jobs and

3. "It is this sadness; I don't know how to say why not. It is a sadness that you have, that doesn't have a reason, because, thanks to God, I am happily married and I love my daughter, and I don't have debts ,but it's a loneliness ,a sadness...what I like is to stay home, alone, preferably lying down and isolating myself from everything."
4. "I don't know, I find myself feeling bad because I'm alone...And of course, feeling lonely depresses me."

financially support themselves. Consequently, as their work hours increase, the social gatherings tend to decrease. These social gatherings were a part of their cultural preventive process against depression. (Barreto, 1993; Moreira, 2002 and 2003). A cultural and critical discussion about loneliness considers that this experience varies enormously from culture to culture. For example, the North American culture places great value in autonomy, with the attitude of “each one for himself.” Although this process is decreasing with globalization, there are still large families in Brazil, and socialization there is something sought and treasured. Loneliness in the United States, thus, would mean being capable, independent, and successful, whereas in Brazil loneliness means failure, abandonment, and social disability.

There is a difference between the two types of loneliness in the subjects’ descriptions. The first one is related to the fact of being alone, that is, not interacting with other people for several reasons, especially for excessive work both in Fortaleza and in Santiago. The second type of loneliness is one in which the person feels lonely even when surrounded by other people and family. The latter is type of loneliness could be seen as a symptom of depression, which is much more an ontological lived experience than a concrete lived situation. In both cases, loneliness is real. It is an actual experience, and is associated with depression by the collaborating subjects. In the speeches of the subjects in this research, loneliness appears both as an etiological factor and as a symptom. Future research on the relationship between loneliness and depression may explain the extent to which loneliness is a consequence of depression (symptom), or how much it is a cause of depression (etiology).

3) *Grief and Loss Processes*

A depressão me deu quando me separei. Eu sentia como se nunca mais fosse ter vontade de viver, me sentia fracassado.⁵

Eh, bueno lo que afecta también es cuando se muere, se le muere alguien a uno, porque a mí la primera depresión que me encontraron a mí, fue cuando murió mi mamá, la muerte también...⁶

But after my mother died I had a nervous break down and I was in hospitals

5. “Depression came when I got divorced... I felt as if I would never want to live, I felt as if I have failed.”
6. “Eh, Well what also affects is when someone dies, se le muere alguien a uno, because with me, the first depression was when my mother died, la muerte también...”

and hospitals, I, ahh, I tried, I tried to kill myself, I was, was very, very...depressed when she died.

This topic emerged the most during the interviews in the three countries. A great number of the collaborating subjects related their depression to the loss of loved ones, be it by death or by divorce, but especially by death. It is worth noting, however, that none of the subjects described death as the only reason for depression. Death of loved ones always seemed to be associated to other factors, such as traumatic childhood, financial problems, and the accumulation of tasks. This issue corroborates the validity of the medical treatment of depression in most of these cases and needs further investigation. Based on the critical literature review about depression and culture, which points out the increase of sadness in the contemporary world, one could reasonably ask in most of the interviews related to loss processes, is the condition experienced really a clinical case of depression? Or, is it the natural grief from psychological suffering caused by the loss of a loved one through death or otherwise?

4) Family history of disaffection, violence and alcohol abuse

... É essa depressão, ela é desde... porque eu fui criada num lar com muitos problemas, sabe? Meu pai bebia muito e eu presenciei todo o sofrimento forte da minha mãe... Era aquela guerra direto lá dentro de casa, constante, e eu presenciei muito ele querendo matar minha mãe, não só eu como meus irmãos e toda vez que eu via aquela cena muito triste (choraminga) eu procurava ajudar a minha mãe, eu procurava socorrer, fazer alguma coisa... Ele dava em nós era de pau, era com o que ele pegasse... Então tudo isso eu passei, vi muitos mau tratos da minha mãe, querendo dar um jeito e sem poder, né?⁷

Mi depresión...es porque he tenido una mala, mala historia de vida...Fui muy golpeada, me pegaron mucho, eh, yo soy la mayor de, de seis hermanos, y a mí siempre me maltrataron, siempre... y, lo único que quería irme de mi casa,

7. "... It's this depression, it is since... because I was raised in a problematic home, you know? My father used to drink a lot and I was there through all of my mother's strong suffering... There was a constant war at the house, and I was there when he wanted to kill my mother, not only me, but my brother as well. And every time I saw that sad scene (weeps) I tried to help my mother, I tried to rescue, just do something... He beat us with a wood stick, was like as he would get... Then I've been through all of this, I saw my mother being really mistreated, I wanted to do something and I couldn't, isn't that right?"
8. "My depression... is because I had a bad history of life, bad history of life...I was hit really bad, they got me too much, ah, I'm the oldest of six brothers and sisters, and me, they always mistreated me, always...and, I was the only one who wanted to leave the house, I wanted

quería irme, irme, irme, y, encontré un pololo y, y me fui con él, porque quería irme, y me salió peor porque después él me pegaba, también me maltrato harto tiempo, y anduve sufriendo por ahí, por allá...⁸

I was depressing, ...I was taking the blame for the things that happened to me when I was a child in my life and so what I did I always took the blame for everything that happened because if I was sexually abused I took the blame, it was my fault and my parents divorced it was my fault, humm ... I have a lot more separations and abandonment in my life, it was all my fault I didn't have a voice so I never said anything so what I did: I internalized everything

Life history of family disaffection appears in most of the collaborating subjects' speech in the three countries. Most of the interviewed people had a personal history of violence, spanking, and sexual abuse, all of which related to their actual depressive state. In Fortaleza and Santiago, disaffection frequently correlates to an estranged relationship with the mother. Most of the interviewed subjects mention a lack of maternal love, which suggests a need for future research.

In Santiago, the theme of alcohol abuse more frequently is associated with domestic violence within the familial environment. Although domestic violence is present in the subjects' speech in the three countries, reference to it is more frequent and more emphasized in the Chileans' speech, which corroborates referent literature to a high incidence of female and child abuse in that country (Moreira, 1999b e 2000). Even though violence is also present in the speech of the Brazilian interviewees, it is mostly associated with the violence in the streets. That is, in Chile the violence is more frequently 'locked between four walls', whereas in Brazil it takes place especially 'on the streets' (DaMatta, 1991 and 1997). This may result from the more 'locked up' Chileans' subjectivity (Moreira, 1999a).

5) Medication

Graças a Deus eu aqui tô tomando remédio pra melhorar mais, né? Tem dia que falta remédio e as carne treme toda e enquanto não toma esse tal de

to leave, leave, leave, and, I found a boyfriend and i left with him, because I wanted to live, and it turned out worst because than he would grab me, and he also mistreated me for a long time ,and went around suffering here, and there..."

9. "Thank God I'm here taking these medicines to get better, isn't that right? There are days that are out of medication and I shiver a lot and while I don't take these so called "diazepam" that the doctor prescribed, I take two in the morning and one at night, if I don't take them I almost fall on the floor, and I don't even feel anything, I have to take the medicine to control my nerves, isn't that right?"

“diazepan” que a Dra passou, eu tomo 2 de manhã e um de noite, se não tomar as carne veia só falta cair tudo no chão, eu nem sinto mais nada, eu preciso tomar o remédio pra controlar os nervo, né?”

Mi modo de vivir, no sé poh la depresión te consume, porque una no, no tiene fuerzas pa’ nada, pa’ ninguna cosa, ni siquiera de abrir los ojos, y cuando al menos com pastilla y todo, me siento bien poh, me siento más liviana, no pienso en nada, y, y vivo mi vida normal no más poh, pero sin pastillas soy un fracaso...¹⁰

Under medication (misspell) I can work, I can do things... but if I have none of medication, I’m really out resort, I’m not really good that’s why my way of living. I can’t live, I just really...I just don’t wanna live, I don’t care if I live.

The biomedical comprehension of the lived experience is unanimous in the three countries; the medication directly relates to depression, which confirms literature associating the current depression epidemic to the psychopharmacological findings of antidepressants in the last 50 years. The medication emerges as a symbol of “getting better” in the three countries. In the United States, however, the issue regarding medication has more emphasis. All interviews that took place in Boston refer to the use of medication, which does not occur in Fortaleza or in Santiago. Moreover, these findings may correlate with the high development of the North American pharmaceutical industry. The question to be born in mind in light of a cultural-critical approach is whether the medicines and treatments prescribed actually treat the disease called depression. Then again, are they simply eliminating the symptoms by working as mufflers of social suffering, hiding the sadness and functioning as the painkillers of social abuse? Only one out of 72 interviewees in the United States stated that his depression only had some improvement with medication, regardless of his life situation:

I don’t know, I, it doesn’t help the situation to my depression, I don’t believe at all that this or that situation really affect that much, despite having this kind of (pause) amazing housing situation almost giving to me, it seems, it is a very good situation! But even having all this wonderful everybody, you know, it is true that things are going well, hum I still feel horrible! (...) You know, it’s not because something is happening, but it’s because that’s how I feel, whatever good chemicals, whatever good grain chemistry is doing!

10. “My way of living, no sé poh la depression consumes oneself, because you don’t have strength to do anything, to anything, don’t even want to open the eyes, and at least with the pills I feel good, I feel more light weight, I don’t think in anything, and, I live my life normally, but with no pills I’m a failure.”

6) *Work, tasks accumulation, competition*

Ela (a depressão) veio aumentando mais com algumas situações que foram assim, acho assim, eu não tenho certeza, que foram criadas pelo meu trabalho, que lá é um pouco difícil e passo por situações que você não consegue resolver.¹¹

...con mucha competitividad, dedicado al trabajo, dedicado a la parte del éxito, y con poco preocupación de otros aspectos de la vida, lo que hizo que efectivamente me fuera bastante bien profesionalmente, económicamente, pero el resto de mi vida se convirtió en un desastre, entonces, yo ahí fui forjando, armando depresión...¹²

I don't talk for Brazil, but for the United States to be a sort of an acceptable member of society you have to hold the job, you know, that's like for membership, if you don't hold the job you are a second class citizen and I felt that way when I was not working.

These accounts introduce an unavoidable aspect of the contemporary world: depression related to work. Several interviews mentioned that work induces suffering in life due to stress, lack of time and family distance. The discourses both in Fortaleza and in Santiago consistently revealed the association of depression to work stress. In the latter, it is especially associated with existing pressures in the work world, in the sense of having to live up to the bosses' expectations and volume of tasks. In all interviews both in Brazil and in Chile, work was referred to negatively. The main complaint focused especially on two points: discomfort in the work environment, and stressful jobs. Such a situation is very frequent nowadays in Latin America, where there is an increasing demand for professionals to live up to the labor market. With profits as a focus, there is a decrease of personnel and employee replacement, most times occurring without proper preparation for the new task. Despite this, there is still a demand for these employees to perform their task well enough or risk losing their job. Some of the subjects in Brazil mentioned that due to depression, they are on medical leave and do not wish to go back to work.

11. "It (depression) started increasing more with some situations that were, I think, I'm not sure, that were created by my work, is a bit difficult there and sometimes I'm in situations that I can't solve."

12. "...with so much competition, dedication to work, dedication to the successful outcome, and with little worries of life's other aspects, what I did was really good, was good professionally speaking, economically, but everything else in my life turned in a disaster, so, I was shaping, putting up depression..."

Depression due to lack of time and the accumulation of tasks emerges in the accounts of Chilean and Brazilian mothers and homemakers who also work outside the house. The relation between depression and task accumulation confirms previous research results about depression in women (Stoppard & McMullen, 2003).

In the United States, the work theme does not emerge as frequently as in Brazil and in Chile, probably because most of interviewed subjects were unemployed, and were living from social security financial aid, which would not occur in Latin America where the minimum wage old age pension is not enough to cover basic expenses of an individual. In Boston, the work theme surfaces in one of the interviewed subjects who referred to the type of depression specifically caused by working, from the sensation of failing the job: "I remember, I had like hummm (pause) 'work depression' (...) Yeah, I had work depression (...) You know, it's hard, it's like if I do no good, you know, what ever I do I do no good".

A more in-depth discussion about a competitive society, emphasizing work, and productivity emerges in the Chileans' and North Americans' speech, yet it does not surface in the Brazilians' speech. They do not get into a wider reflexive discussion of social order regarding their problems. That means the Brazilian interviewees, despite their complaining about work overload, do not reflect on the competitive market in the contemporary world, as do the North Americans and Chileans. This fact could be linked to the intellectual level of the interviewed subjects in the three countries. Despite the fact that being in a public institution was an inclusion criterion for interviewees to assist in this research, the lower class in Brazil is not at a comparable level to the lower class in neither the United States nor Chile; these two countries have a far better social and economical situation than Brazil.

7) *Financial difficulties/ unemployment*

Aí veio a depressão... eu me sentia inútil, porque você é acostumada a trabalhar desde nova e tem coragem de trabalhar e aí você vai atrás de um emprego e fecham as portas, né?¹³

Y en realidad lo que a mi mas me, me preocupa es, es la situación económica no mas, ah eso me lleva todo al, al no en la boca, y porque mis hijos, tengo 3 niños

13. "Than, depression came...I felt so useless, because if you are used to work since you're young and have courage to work...and than, you go find a job and they close he doors."

estudiando y en realidad no me exigen, pero piden, entonces yo con el no, no, y también me hace mal eso...¹⁴

Ah, I feel depressed when I'm not working, when I don't have the money, you know, I get depressed like that and I feel depressed when I don't have enough food to eat when I don't have the money to supply...

Depression associated with financial difficulties, unemployment and poverty is the most frequent theme in the Brazilian interviews. Most of the Brazilian subjects connected depression to the impossibility to buy food and other items, as well as not being able to fulfill children's demands. The willingness to find work coupled with that impossibility represents the suffering of those people, feeling powerless and facing a situation they cannot change. They associate their depression with the sensation of uselessness and powerlessness (Moreira, 2002). Hopelessness stemming from unemployment, although less frequent and serious, transpires in Chilean and in North American interviews as well.

8) Social discrimination / Stigma

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Eu agora digo assim, que sou discriminada por três coisas: discriminada pelo marido, discriminada porque sou velha e discriminada porque moro num bairro pobre, no Pirambú, aí quando perguntam onde eu moro que digo que é no Pirambú o povo diz: "Vixe. Isso tudo vai acabando com agente. Agora mais isso... Por isso que eu tenho vontade de morrer porque eu morrendo, acaba, acabou."¹⁵

*Lo que pasa es que la gente lo toma a la chacota, te ve poco menos como loco: ya este es depresivo, es enfermo de los nervios (...) porque a lo mejor la gente que te rodea no esta preparado para recibir una persona que ha tenido, que es depresivo.*¹⁶

14. "And in reality, what concerns me more, is the economical situation, all this brings nothing to the mouth, and because my children...I have three children in school and they don't demand, but they ask for it... me with him, no, no, this also make me feel bad."

15. "Now I say this, I'm discriminated for three things: discriminated by my husband, discriminated because I'm old and discriminated because I live in a poor neighborhood, Pirambu. And when people ask where I live and I say is in Pirambu, they say: "jeez..." all that starts to devastate us. And now, there is this. That's because I want to die, because if I die, it all ends."

16. "What happens is that people don't take it seriously, have us as crazy: "this is depressive... 'sick of the nerves' (...) because even th best people that have you around are not prepared to receive someone who has or had depression"

Racism... Cause I, cause I even get, ah, nasty comments, from my own race and nationality of people... Ah, the way ah, the way people act, some people act, and the way some people treat me (...) when I was younger... I was wanted to play with kids; I wanted to play with black kids and other kids besides Black. My father thought I was favoring other races of people, but I really wasn't, I was just being me!

The Brazilians interviewed associated their depression with a social discrimination experience. These inequities related to poverty and marginality (living in a poor neighborhood, being considered strange), age (becoming unproductive for society and being unable to have a job), and the prejudice against homosexuality (hiding from fear of judgment, not assuming his real sexuality), which, despite being less explicit, is also associated with the stigma of mental illness. Some of the Chileans interviewed made explicit allusions to mental illness stigmas in their work environment. However, the North American subjects are the only ones who associated their racism experiences to their depression.

Moreover, discrimination and stigma emerge in the three sample's speech, but the types of biases are different, and they relate to each culture. In Fortaleza, a city of large social and economic discrepancies (representative of the whole of Brazil), discrimination emerges simply from being poor. In Boston, the connection between depression and racism materialized, alluding to the long history of racism in the United States. This does not mean to imply a lack of racism in Brazil or to deny that classism exists in Boston. The results were striking because depression was primarily associated with the historical subjectivity processes of each culture or specific people.

9) *Urban violence*

Depressão é medo... Medo de ir bem ali e alguém te pegar. Medo de uma bala perdida. Medo de a guerra vir até aqui e levar alguém seu, da sua família. Entendeu, medo de tudo...de tudo¹⁷

The relation between urban violence and depression arises only in the interviews set in Brazil. Although this type of violence exists in both Chile and in the United States, its level of intensity is not as striking as in Brazil. This is obviously related to Brazil being a country with one of the largest social discrepancies in the world. This fact contributes to the daily increase of urban

17. "Depression is fear...Fear of going right there and someone catching you. Fear of missed bullets. Fear of war coming right here and taking someone from your family. Understand? Fear of everything...everything."

violence, leading to stress, tension, and suffering due to the emotional distress of those living in a constant alert state for fear of violence. Future researchers could investigate how the depression etiology of Brazil is changing due to the inexorable urban violence.

10) Religiosity

Although Brazilians and Chileans occasionally mentioned religious aspects, the interviewed subjects do not directly relate their depression to religion. These are interesting findings which do not confirm previous studies showing that psychopathological experience in Brazil has simultaneously a spiritual and medical meaning (Freire & Moreira, 2003; Moreira & Coelho Junior, 2003).

Conclusion

The results of this study corroborate the depression symptoms shown by previous research. Nonetheless, these results show that even though there is no transcultural variation in the symptomatology of depression, there is a difference with regard to the experiences, connected to the characteristic subjectivity process of each culture. On one hand, they show that the contemporary way of life contributes to the emergence and maintenance of depression through specific cultural subjective processes. On the other hand, the largest part of the reported depressive experience is associated with life situations of social and psychological suffering. Therefore, as was previously discussed, it is hard to identify whether these people are “ill”, or are merely experiencing sadness and psychological suffering.

The analysis of the interviews shows an experience of pain relating to economic privation, violence, sexual abuse, lack of care, and unemployment. Therefore, depression seems natural for these life situations. As Martin-Baro points out (1985, 1989 and 1994), in these circumstances, feeling depressed is neither a pathology nor an “abnormality”, but a “normal” natural consequence, emerging from an “abnormal” social living situation. In most of the interviews, it is impossible to identify if it is pathology or an emotional state or mood variation, due to oppressive life experiences (Moreira & Sloan, 2002). As was previously mentioned, only one out of the 72 interviewed patients in the three countries has clearly confirmed that his depression has nothing to do with his life situation. That is, even if the interviewed people have, in fact, pathology of

depression, as they think they do (the inclusion criteria in this research was that the person would see him or herself as someone who had the diagnosis of depression), this illness is deeply interwoven with historical and social aspects in these peoples' lives. Having said that, this research corroborates the Critical Psychopathology perspective (Moreira & Sloan, 2002), in the criticism of individualistic psychological theories that understand the pathology being due to purely individual responsibility, emphasizing biomedical ideology. These findings suggest a need of more attention by the mental health professionals in order to avoid a possible medicalization of sadness and psychological suffering, turning oppressive psychosocial situations into an illness treated with medicine. Depression described in this research is a psychosocial illness, whose treatment needs to go beyond biomedical ideology.

It is important, nevertheless, to point out the limitations of this research. One of these could be the fact that the collaborating subjects were selected by their self-reported diagnosis of depression. However, this was a criterion because the main point studied was the lived experience of the person who thought of himself/herself as having depression, independently of how depression was defined. So, this study does not examine the etiology of depression, nor does it analyze whether social biological or both sets of factors lead or cause depression. Rather it examines how people who think they have the disorder construe the experience, which includes their perception of the etiology of the disorder.

One other interesting point relating to the selection process of the subjects is that all people from Fortaleza and Santiago happily agreed to participate in the research. In Boston, four invited people did not agree to participate because they would not be paid for their responses.

It is important to remind that this qualitative study does not intend to generalize the obtained results. We are talking about research that took place in three cities: Fortaleza, Santiago and Boston. This does not necessarily represent the countries where these cities are located, let alone their culture, if one is to consider the complexity of meaning of the term *culture*. It is exceedingly important to state, at this point, as to avoid misnaming a transcultural study for a mere comparison of data gathered in different countries or cities within such countries (Moreira & Sloan, 2002). As a case in point, the instance of racism relating to depression only in the North American interviews does not mean that racism is not present in the depressive experiences in Chile or Brazil. One could reasonably claim, on anthropological and social-historical facts of these three countries, that racism would be more apparent in the history of North American patients where the society is increasingly multi-cultural. Likewise, one could also

argue that urban violence is strongly associated to the depressive experience in Brazilian patients because it invades Brazilians' contemporary everyday life.

Yet it cannot be said that violence does bring about depression in Brazil and racism causes depression in United States. Instead, these experiences, as part of these peoples' subjective experiences, constitute the psychopathological experience and contribute to the process of coming down with an illness. In a "merleau-pontyan" phenomenological language, the experience described in depression is worldly, and has multiple contours (Moreira, 2001, 2002, 2003, Sam & Moreira, 2002). Hence, even though a variation in the description of the symptoms of depression across cultures has not been found, there is a variation in the meaning of the lived experience. It relates to grief, life history of disaffection, violence, alcohol abuse, loneliness, unemployment, racism, or urban violence. The intensity of each varies and depends on the subjectivity processes in each culture. That is, depression exists in mutual constitution with the world, or the several worlds.

Other limitations of this research exist. Among them, the gender issue: of the total number of interviewees, only one third of the interviewed subjects were men, making the women the largest part of the sample. This cannot be disregarded, because it corroborates the wide literature indicating that the major incidence of depression occurs in women. Another limitation of a qualitative transcultural study is the variation in the conduct of the interviews. Although the main researcher trained the interviewers in phenomenological methodology, there is always a variation in the administration of interviews. Another restraint is the level of the researcher's familiarity with the different cultures, which is crucial when comparing the results so as not to lose sight of each culture's singularity in each sample. Because the principal investigator of this study has lived in all three countries, it allowed for a better comprehension of experiences related in the interviews. She had some knowledge about the kind of patients helped in the school clinic school at the Universidade de Fortaleza, at CAPS in Fortaleza and at the Universidad de Santiago de Chile, even though she conducted the interviews in Fortaleza or in Santiago. The fieldwork performed in the Center House located in Boston, where the principal investigator immersed herself in the interviewees' cultural reality was more productive. This suggests an implementation of future phenomenological and ethnographic research, allowing the researcher to learn more about the cultural reality being studied, helping him or her to understand the meaning of the lived experience or the '*lebenswelt*' (the lived world).

Finally, this article discusses the major conclusions of the research. However, the large amount of data collected throughout the four-year project suggests a scrap of the results for possible mapping in future studies. This may allow for a

more in-depth understanding of the emerging contemporary social and cultural themes identified as relating to the lived experience of depression in Fortaleza, Santiago, and Boston. These themes are depression *vs.* loneliness, depression *vs.* unemployment, depression *vs.* grief, depression *vs.* work, depression *vs.* Poverty, depression *vs.* urban violence, and depression *vs.* racism. This research confirms that depression is not an illness whose etiology is purely biological or individual. Depression exists in mutual constitution with the world, or with the many different worlds. The development of many other qualitative and transcultural researches on depression is necessary for a more in-depth comprehension of the meaning of depression in the contemporary world, including the intersections with specific cultural subjectivity processes. Without a doubt, if there is more emphasis on the ideological and cultural aspects of this suffering, it can significantly slow the epidemic of depression in today's world. Considering that the more known about treatments of depression, the more depression increases, we hope this research contributes to the inversion of this process. That is, we hope that these findings play a part to decrease depression cases, mostly by not feeding the "psy" market.

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Resumos

Este estudio objetiva comprender el significado de la experiencia vivida de la depresión en Brasil, Chile y Estados Unidos, con el enfoque en posibles variaciones culturales que puedan contribuir para una comprensión transcultural. Entre 2000 y 2004, 72 adultos con depresión o registros clínicos de depresión (n=30 en Fortaleza, n=22 en Santiago, n=20 en Boston) fueron sometidos a entrevistas fenomenológicas que investigaron la descripción de la experiencia vivida de depresión. Los resultados

muestran que, aunque no haya variación en la sintomatología entre los tres países, la experiencia asociada a estos síntomas varía de acuerdo con los diferentes procesos culturales subjetivos que son característicos de cada cultura. Concluyendo, estilos de vida contemporáneos, juntamente con algunas mudanzas culturales, inclusive opresión económica y psicosocial, contribuyen para el surgimiento y manutención de la depresión.

Palabras – claves: *depression, fenomenología crítica, transcultural.*

Cet étude a como but comprendre la signification de l'expérience vécue dans la dépression au Brésil, au Chili et aux États Unis enfocant possibles variacions culturelles qui puissent contribuer pour sa compréhension transculturel. Entre 2000 et 2004, 72 adultes avec dépression ou histoire clinique de dépression (n=30 a Fortaleza, n=22 a Santiago et n= 20 a Boston) ont été soumis a des entrevues phénoménologiques que recherchent la description de l' expérience vécue de la dépression. Les resultats montrent que, si bien qu'il n' y ait pas de variation de la symptomatologie dans les trois pays, l' expérience vécue associé avec ces symptomes change en accord avec les différentes procés culturels subjectifs, que son caracteristiques de chaque culture. En conclusion, les styles de vie contemporains, en ensemble avec les changements culturels et l'opression économique et psicosocial contribuent pour le debut et mantención de la dépression.

Mots-clés: *depression, phenomenologie critique, transculturel.*

Este estudo tem como objetivo compreender o significado da experiência vivida da depressão no Brasil, Chile e Estados Unidos, enfocando possíveis variações culturais que possam contribuir para o seu entendimento transcultural. Entre 2000 e 2004, 72 adultos com depressão ou registros clínicos de depressão (n=30 em Fortaleza, n=22 em Santiago, n=20 em Boston) foram submetidos a entrevistas fenomenológicas que investigaram a descrição da experiência vivida de depressão. Os resultados mostram que, ainda que não haja variação na sintomatologia entre os três países, a experiência vivida associada a estes sintomas varia de acordo com os diferentes processos culturais subjetivos que são característicos de cada cultura. Concluindo, estilos de vida contemporâneos, juntamente com algumas mudanças culturais, inclusive opressão econômica e psicossocial, contribuem para o surgimento e manutensão da depressão.

Palavras – chave: *depressão, fenomenologia crítica, transcultural.*

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