Feeling cold in winter: 
Ethiopian Migrants' Conceptualization of Depressive Illness

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Chapter One

I. Background

History of Depression

The history of mental illness and mental health care, though non-systematic, can be traced back to the time of ancient Greek civilization. The Greek physician Hippocrates (460-377 BC) viewed ‘abnormal’ behavior as a result of bodily processes such as disease or an imbalance in bodily fluids. His theory of mental illness was insistent that all illnesses or mental disorders must be explained on the basis of natural causes. Unpleasant dreams and anxiety were seen as being caused by a sudden flow of bile to the brain; melancholia was thought to be brought by an excess of black bile and exaltation by a predominance of warmth and dampness in the brain. He recommended rest, exercise, and dietary change as treatment. Around the fourth century, when Christianity had grown to the official religion, the way of looking at mental illnesses has also changed accordingly. In the Middle Ages, however, mental illnesses were seen as a result of the displeasure of gods or demonic possession. This was largely a concomitant of the zeitgeist of the Christian faith, spiritual values, miracles and the prevailing philosophy of scholasticism. Treatments naturally included exorcism, flogging or torture to drive the evil spirits from the body. [1,2]

Later, in the eighteenth and nineteenth century, when more scientific ideas and models prevailed, the French physician Phillipe Pinel played a pioneering role in bringing humane treatment to the mental health hospitals of Paris. The first systematic concern for the role of cultural factors in the etiology of mental disorders is, as to Marsella (1979:234), credited to the Swiss philosopher Jean Jacques Rousseau. In 1749, Rousseau claimed that man is inherently good; it is the social customs and cultural institutions that have made him mad. The vices of civilization as causes of human problems became a target for reform efforts such as romanticism. This also yielded to a closer examination of the role of the sociocultural milieu in mental disorders. [3]
Emil Kraepelin, a German psychiatrist, made the first major advances in the identification of different types of mental disorders. Kraepelin, after analyzing thousands of case histories, classified mental diseases according to their cause, symptomatology, course, final stage, and produced a system of nosology. His classification of mental disorders served as the foundation for the present day Diagnostic and Statistical Manual (DSM) and the International Classification of Diseases (ICD). In addition, he reported cultural differences in the expression and frequency of mental disorders among various populations in Indonesia. His attempts can be regarded as one of the earliest cross-cultural field investigations in the area of mental health.[3,4]

In the nineteenth century, mental illness was thought to be the result of organic causes. Studies on partial paralysis revealed that it is a condition that comes at a late stage of syphilis. This strengthened the idea that mental disorders might have biological roots. Toward the end of the nineteenth and the beginning of the last century, a number of physicians studied the psychological basis of mental illness. The publication of Civilization and Discontents by Sigmund Freud enlivened the notion that social (in the psychic/developmental sense) factors are the source of human problems, especially mental disorders. [5]

The development of the cross-cultural method by Edward Tylor in 1889 and successive ventures by Wheeler, Ginsberg and Horton in the application of the method to apprehend the connection between and among cultural and psychological variables have also contributed to the present day cross-cultural theories and disciplines. From then on, numerous research efforts to delineate the role of cultural factors in the conception and treatment of mental disorders, the influence they have on the expression of well known and other culture-bound disorders had been undertaken in the 50's and 60's. [For a detailed discussion, see Marsella (1979)]. These studies have led to the proliferation of cross-cultural studies that focused on the ethnocentricity of Western concepts about the expression and treatment of mental disorders. They also contributed to a heightened recognition of cultural differences in the understanding, expression and experience of mental disorders and increased felt need for culturally appropriate interventions.
To sum up, this relatively short tradition of cross-cultural studies has led to the generation of ideas, the formulation of models and theoretical perspectives that took the link between mental disorders and culture as the nucleus of inquiry. In this sketchy and general background of mental illnesses, the efforts made to know their causes and thereby arrive at treatment approaches, the shifts in the explanations from humoral beliefs to religious explanations, then to social institutions and finally to organic origins; and the emergence of cross-cultural studies are shown.

Depression, as one of the mental illnesses, has long annals in Western medical history. Historical accounts have it that this mental disorder had been described in Greek, Roman and Medieval times in a similar way as it is described nowadays by psychiatrists. [6,7] The definition and application of the term ‘depression’ is remarkably complex. A depressive disorder is often considered as an illness that involves the body, mood and thoughts. It affects how a person feels, acts and thinks about life. In short, it has a physical, emotional and cognitive nature. For diagnostic purposes, depression is characterized by nine classic symptoms [see Appendix A]. A major depression, also known as unipolar/clinical depression, is present if five or more of the symptoms are present for at least a two-week period or as long as several months or longer. [8] When the same symptoms persist to appear but in milder forms on the individual for at least two years, a second type of depression-dysthemia- is indicated. The less common form-manic-depression or bipolar disorder- involves disruptive cycles of depressive symptoms that alternate with mania or euphoria.

Depression, as observed by Kleinman and Good (1985), can be a symptom, an illness or an emotion. They noted the different way conceptualizing depression in anthropology in the following excerpt.

"...For the clinician, depression is a common, often severe, sometimes mortal disease with characteristic affective (sadness, irritability, joylessness), cognitive (difficulty concentrating, memory disturbance), and vegetative (sleep, appetite, energy disturbances) complaints which has a typical course and predictable response rates to treatment. Thousands of studies implicate neurotransmitter, neuroendocrine, and autonomic nervous system malfunctioning. This is not the ‘depression’ of the ethnographer, for whom the word denotes a fleeting state of sadness, hopelessness, and demoralization that may be as fleeting as momentary nostalgia or as lasting as prolonged grieving. For the clinician, grief is not a clinical depression, though it may come so; for the ethnographer depression is often conceived as a form of grief and grief as a type of depression.” (p.9) [7]
It is an idée reçue that psychiatric disorders appear in all cultures. However, their form and expression is very much a product of cultural belief systems. Anthropological studies reveal that cultural beliefs about the nature of mental illness significantly influence the group’s view on the status, course and treatment of the problem. Culture determines how individuals view their mental and physical health. Cultural beliefs and traditions of a particular society shape the views on the etiology and nature of health problems it faces and in turn determine the method of treatment. As Castillo (1997) noted, there are five ways that culture affects clinical reality. These include (1) culture-based subjective experience; (2) culture-based idioms of distress; (3) culture-based diagnoses (4) culture-based treatments and (5) culture-based outcomes. [9]

In an excellent article on the place of culture in Diagnostic Statistical Manual–IV, Mezzich et.al. (1998) summarize the ways by which culture is intricately tied to psychiatric diagnosis and evaluation. Culture, they write,

1. Shapes the phenomenology of symptoms themselves, their content, meaning and configuration;

2. Is manifested through ethnopsychiatric diagnostic rationale and practices of grouping symptoms together into pattern that include but are not limited to the familiar culture-bound syndromes found in various societies;

3. Provides the matrix for interpersonal situation of the diagnostic interview; and

4. Informs the overall conceptualization of diagnostic systems. (p. 458). [10]

In line with the first and second points, members of cultures and subcultures share social and historical traditions, challenges, opportunities, and stresses that in the course of time provide a common core of experience. This core of experiences naturally gives rise to a unique cultural scenario that greatly shapes how psychological processes are understood, experienced, and expressed with in that culture. [11] This research revolves primarily around the culturally shaped conceptualizations and understanding of depressive illness among Ethiopian migrants who live in the Netherlands.
Statement of the problem

In the introductory statement to the WHO constitution, health has broadly been defined as a state of complete physical, social and mental well-being, not only the absence of disease. In this all-embracing definition, due attention and consideration has been accorded to the issue of mental health as part of the definition of health. Worldwide, mental illness accounts for a large proportion of disability due to disease and imposes a heavy burden in terms of “human suffering, stigmatization of the mentally ill and their families, and direct and indirect costs.”[12] At present, according to WHO's report, approximately 1500 million people are estimated to be suffering from some kind of neuropsychiatric disorder worldwide. [13] Out of these psychiatric disorders, WHO and The Economist reported that depression is the most widespread and significant mental health problem. While not taken seriously enough, there are 340 million people suffering from it, 90% of who get inadequate treatment and most cases are not even diagnosed. Beyond the pain, suffering and decreased productivity depression entails, it is a potential killer (1.6% of world deaths and 60% of suicides are accountable to depression). This disorder afflicts more people than cardiovascular diseases and even far more than AIDS. [13,14]

As to one international study in which 17 researchers gathered data on 38,000 participants from ten countries, it was found that rates of major depression in different countries varied by a factor of ten. The results suggest that cultural differences and different risk factors may affect the expression of the disorder. The lifetime risk of depression (defined as the probability that an individual will suffer at least one episode lasting a year or more) ranged from 1.5% in Taiwan to 19% in Lebanon. The authors acknowledge that some, if not all, of the variations could be a result of under or over reporting problems. Some general epidemiological patterns of depression hold for many countries. In his summary of multicultural studies on clinical depression, Horgan noted that in every country women were roughly twice as likely as men to suffer from depression. [15] Controlling age and sex, Holzer et.al found out in their study on ethnicity, social status and psychiatric disorders that there is a joint relationship between ethnicity and socio-economic status with psychiatric disorders. The greatest increase in risk factors appeared in the lower social and economic category. [16] This problem is also prevalent among minority groups such as immigrants and refugees. It is
anthropologically fascinating and practically rewarding to explore how this mental problem is viewed, experienced and handled among these special groups of people from a cross-cultural point of view.

The increasing trend in cross-cultural studies is a result of a confluence of quite a number of factors. Transnational mobility of humankind, one among the many, has increased enormously in the course of the last century. Hundred years ago, as Wichert remarked, world travel was unusual and newsworthy. [17] With technological advancement, that made safe and speedy travel possible, has come immensely increased international and intercultural communication. The accessibility of world travel has not only benefited tourism, scholarship and commerce but also allowed immigration to a greater extent. The importance and problems associated with this ever increasing intercultural communication on an international level is observed by Belay (1993) when he wrote:

“Physical interconnectedness and interdependence among cultures and nations has reached a much higher level of development than the awareness and competency required from both individuals and institutions to handle this new reality. (p. 440) [18]

One of the platforms where this question of “awareness and competence” among individuals, institutions and systems in dealing with issues fraternized with intercultural communication manifests itself is in the area of mental health care. The focus of interest in this research is on the exploration and detailed description of Ethiopian migrants’ views and conceptualization of the nature, causes, types, illness experiences and treatment of depressive illness.

The United Nations define the immigrant stock as consisting of all inhabitants who were born abroad and who have been living in the country for more than one year. This definition has been modified to suit the situation in the Netherlands. Thus, the narrow definition of the concept of immigrant stock, as it is called, refers “the population with a foreign background which includes all inhabitants who were born abroad and who have at least one parent who was born abroad (the first generation) plus those who were born in the Netherlands and whose parents were born both abroad (the second generation). (De Beer (1995) quoted in ECE Work Session on Migration Statistics)(p.3) [19] According to the forecast of the Dutch foreign population (1996-2015) compiled by StatNeth, ...
the population group from non-western countries will show the strongest growth. In 1997, this group numbered 385 thousand. One in three came from an Asian country, over a quarter from Africa, a quarter from Eastern Europe and 10% from Latin America. [19]

Migrants, as one group of intercultural communicants, exhibit symptoms of mental health problems common to the general population but their situation is unique and presents challenges for mental health workers because of issues of diversity that enter the diagnostic and therapeutic relationship. [20] Stressing the idea that cultural knowledge is far from sufficient to provide effective mental health care in the context of the Netherlands, Van Dijk (1989) broadly warrants to language barriers and cultural differences as the most accountable reasons for the challenges in the provision of health care services. [21]

Inclusion of the five sociocultural axes in the Diagnostic and Statistical Manual (fourth edition) by the American Psychiatric Association was an attempt to remedy the omission of culture from the nosology of psychopathology. Despite the changes made in the cataloguing of mental problems, the consideration given to culture and gender, and its attention on special groups like homosexuals, DSM has not turned any more useful for transcultural psychiatric practice in a specific way which is different from its older version. Nevertheless, this international diagnostic instrument and reference prescribes the need for culturally sensitive diagnosis to be done- an important recommendation for cross-cultural mental health care. Notwithstanding, no guidelines or procedural descriptions on the how-of culturally sensitive diagnosis is given. These international documents tend to underlie the assumption that mental disorders are universal phenomena. Anthropologists, however, challenge the validity of this assertion by arguing that the cross cultural investigation of the meaning of indigenous sickness concepts and the possible ‘family resemblances’ between these local concepts and the concept of a particular mental disorder as defined by psychiatrists should be given precedence for better understanding and intervention efforts. [22] Hence, it is hugely important to look into how depression is viewed, interpreted, and communicated in a meaning-making system among Ethiopian migrants living in Holland. In this study, an attempt is made to answer the following basic research questions.
1. How do Ethiopian migrants conceptualize depressive illness—its conceptual status, etiology, forms and manifestations?

2. How are the views, conceptualizations, experiences and expressions of depressive illness shaped by social and cultural dimensions?

3. What help seeking strategies and behaviors do Ethiopian migrants have toward depressive illness?

4. Why are Ethiopian migrants reportedly making less utilization of the mental health care services provided for depressive illness?

Objectives of the Study

This descriptive study is intended to serve the below mentioned six specific objectives. These objectives are detailed breakdowns of the research questions put in a form that can be implemented and evaluated. This study intends:

- To describe the explanatory forms and beliefs Ethiopian migrants have about the essence, causes, types, manifestations, treatment and prognosis of depressive illness in a meaning-making context.
- To investigate the semantic networks i.e. symbols and meaningfully related experiences in relation to the experience and expression of depression.
- To explain how these conceptualizations are molded by sociocultural factors.
- To identify the structural and social conditions associated with depressive illness among Ethiopians as a migrant community in Holland.
- To investigate the help seeking strategies and behaviors of Ethiopian migrants and the reasons for making less use of the psychiatric help from the Dutch professional health sector.
- To see through the commonalities and differences in the conceptualizations of depressive illness among Ethiopian migrants and the psychiatric perspective on the mental disorder.

In all the objectives, a sharper focus is accorded to cultural issues that could be either at the
foreground or at the background of the conception of depressive illness. It is believed that an awareness of the different views, interpretations, explanations and manifestations of depressive illness in other cultures is of great practical significance for appropriate service provision and intervention efforts. It is also hoped that the results of the study could give insights into the roles of cultural factors in the success of helping relationships in light of the diagnosis of depression and the therapeutic attempts directed towards it. In addition, the study has generated few idiographic ideas that could contribute to the existing cross-cultural theoretical framework.

Theoretical perspectives

This section gives a condensed summary of the theories and models that attempt to explain the problem of depression. Broadly speaking, none of these perspectives on the etiology of depression is complete by itself to fully expound the multidimensional aspects of depression as a mental disorder. In this study, adherence to the anthropological perspective is made. However, the field data have also been looked at from the other perspectives, when necessary and relevant, with greater sensitivity to cultural dimensions.

Anthropological perspectives

The anthropological perspective takes culture as the prime domain where the experience, meaning and expression of human emotions is crystallized and the effort to understand them should focus on the investigations of the cosmological views, value and belief systems, customs, personhood and social organization of the society. An understanding of the critical significance of culture to the psychological development of the individual and to the wider understanding of psychiatric disorders in social and clinical work has become enormously important. Culture, as clearly elucidated by Hinton and Kleinman, “is a system of meaningful symbols that orients the subject not only to the outer world but also to the inner world.” [23] Culture shapes and molds our worldview, thinking, feeling and behavior in generally obvious and subtle ways. Besides, culture patterns the perception, evaluation, experience, expression and biopsychological processes and provides alternatives for the experiential organization, communication and expression of emotional distress. As noted by
Kleinman and Good, depression for the anthropologist is far less delineated by clinical parameters but instead by specific social and cultural parameters of the group being studied; and hence the concept tend to be much broader and less universal for the ethnographer.

The important element in this perspective is the importance given to the individual’s and the cultural group’s conception, diagnosis and classification on the basis of the stories and narratives they tell, their opinions, experiences, evaluative judgments, emphasizing a cognitive and contextualised view. In light of this, depression is seen as a socially produced and culturally constructed individual experience in local contexts. Thus, the individual’s depressive illness experience and the social and cultural scenario in which the situation takes place stand out as two essential foci for anthropological research on depression.

The medical model

The dominant model today (at least within psychiatry) is the medical model of psychopathology. The basic assumption of this model is that psychological disorders are medical diseases. The nature of onset, distribution of cases, development and course, treatment response, and associated features observed in psychological disorders are accordingly seen to be parallel to what occurs in physical diseases. This approach embraces reductionism- a philosophical view that complex phenomena (such as thoughts, behaviors, emotions) can be completely understood and explained at a more fundamental level. That is, in this case, thoughts, behaviors and emotions can be "reduced to" the more basic level of biological processes. Depression is thus seen as a neurobiological phenomenon that occurs when there is a shortage of serotonin or insufficient serotonin receptors. In short, this model does not address the meaning, purpose, perceived causes and other micro and macro social and cultural aspects of depressive disorder. [24] Just as with schizophrenia, the most popular neurophysiological theory of depression follows from the drugs that are used to treat it instead of following patients’ experience of depressive illness.
The biopsychosocial model

As an alternative model, the biopsychosocial model attempts to recognize the shortcomings of the medical model. The biopsychosocial model, in contrast to the medical model, conceptualizes disease as a multilevel phenomenon. It rejects the reductionistic bias of the medical model. Most notably, this model shows the continuous interaction between and among the biological, psychological and social dimensions of psychiatric disorders. The biopsychosocial model identifies numerous levels that may be relevant in understanding psychopathology i.e. social, cultural, psychological, biological, and physical variables. It also contends that this hierarchical organization of the different systems requires its own methods of study unique to each level. [25]

Cognitive models

Following the cognitive revolution in the 1960s, psychologists began to apply cognitive theories to better understand affective disorders. Cognitive theories were specially used to explain unipolar/major depression, not bipolar disorders that are supposed to have a completely different system of etiology. Based on electric shock experiments on dogs, Seligman developed his learned helplessness (characterized by lethargy, sluggishness, and loss of appetite) theory. He proposed that this behavior is learned and the general phenomenon was a result of an imagined/felt lack of control, and he formulated it into a theoretical scheme for the understanding of human clinical depression. According to Seligman, if a person is exposed to a stressor and if the individual perceives no control over it, it is most likely that the person will respond with learned helplessness. Abramson, in an attempt to revise Seligman’s theory, added four premises to the schematic frame: expected aversiveness (expecting that highly aversive outcomes are probable), expected uncontrollability (expecting that you will be unable to control situations), and attributional style. [26,27]

In the same cognitive tradition, Aaron Beck devised a schema-based model of depression (cognitive distortion model) to provide a coherent account of the beliefs depressed individuals hold about themselves, the future and the world. The negative events experienced in the past are encrypted in
memory in the form of schemas. Beck believed these schemas- cognitive patterns and styles- are latent and greatly influence the interpretation of events in life. When an individual has negative views on his self, his future and the world in general [three negatively interlocking beliefs], this cognitive triad causes and maintains depression according to the cognitive model.

**Contextual theory of depression**

In the past, causal theories of depression have been used across all populations. These theories have utilized the weaknesses of biological, psychosocial, and sociological models and attempt to explain the occurrence and development of depression. This contextual focus incorporates the neurochemical (biological theory); the impact of losses, stressors, and control/coping strategies (psychosocial theory); the conditioning patterns, social support systems, and social, political, and economic perspectives (sociological theory); and the ethnic and cultural influences which affect physical and psychological development and health. In its approach, this perspective is closer to the biopsychosocial viewpoint. [28,29]
Chapter Two

II. Methodology

In this section, a brief synopsis of the characteristics of the population and target sample for the study is presented. In addition, the data collection tools and techniques together with their rationales and limitations are discussed. Following the description of the three qualitative data analysis methods used in the last phase of the study, the anticipated problems and field experiences are also treated.

Research setting

The study is conducted on twelve Ethiopian migrants who live in the various provinces of the Netherlands: Utrecht, Arnhem, Maastricht, Amsterdam, Almere and Den Delder. There are around 7,992 Ethiopian migrants including Eritreans in the Netherlands. This migrant community is one of the first five largest categories of migrants. Even though the size of the study population is known, its detailed demographic characteristics and other profiles are not found. Similarly, the number and condition of Ethiopian migrants with psychiatric disorders specifically with depressive illness remains undefined. In short, the sampling frame is loosely delineated and its characteristics can not be clearly described.

In this kind of anthropological investigation, it is quite practical and justified to adopt a rather less criterion-bound and less strict sampling procedures. Hence, a snowball sampling technique was used and a total of twelve informants participated in the study. In the course of data collection, the number of informants was decided to be twelve in view of the time available for the fieldwork and the quality and redundancy of the qualitative information. Five of the twelve informants were females [Selam, Meron, Abeba, Kidist, and Hibist-all fictitious names] and only three of them have legal residence. The other two are seeking asylum and waiting for court decision. All but one are married and are older than twenty-five years of age. Regarding the male
informants, only one of them was married. The age range for the male respondents was between 30 and 47.

Data collection methods

Three data gathering methods have been chosen to be appropriate in serving the six specific objectives stated under the section on objectives. They are briefly presented hereunder.

In-depth interview

Using the loosely framed interview schedule I which is organized around broad themes and discussion topics (see Appendix B), it was attempted to gain a deeper understanding and explore links between sociocultural factors and the illness experience, expression/symptom presentation, explanation, treatment progress and outcomes of depressive illness. This method of informal conversation with very limited structure was replaced by a semi-structured interview on condition that when it was less likely to meet the informant again, when specific expert opinion and data on selected parameters such as onset, causes, diagnosis, prognosis etc. were sought. Essays and drawing diagrams were also used to let informants narrate and represent their conceptualization and illness experiences that can later be discussed. All the interviews with the informants were tape recorded for later transcription and field notes were taken on the spot as well.

Focus Group Discussion

This method of data collection was not planned to be used in the original study. After finding out there were no Ethiopian migrant patients with depressive illness utilizing the services provided by the six psychiatric teams/care givers as they are called that work under the de Meren and the Amsterdam Psychiatric Hospital and after coming to learn from the informants that there are quite important issues worthy of investigation and discussion with psychiatrists and social workers who constitute the care giving teams, it was decided to employ the method. These issues were mainly about the reasons why Ethiopian migrants refrain from seeking psychiatric services
despite the seriousness of the problems they have and despite the constant and unfailing effort of the psychiatric team members to extend professional help.

One focus group discussion was organized and held at *de Meren* with the help of one psychiatrist who took a keen professional interest in transcultural psychiatric issues to get the psychiatrists' perspective on the issues. The themes for the group discussions were reasons given by informants for not seeking help for depressive illness and for not making use of psychiatric services. These included:

1. Being used as experimental subjects for clinical trials
2. Being diagnosed as having no psychiatric problem
3. Being suspected as trying to make a *case* for the Police
4. Suspecting invisible communication between the psychiatric hospital and the Police
5. Dropping out when diagnosed as depressive
6. Language problems in psychiatric contact
7. Lack of trust in the capacity of the psychiatrists to bring meaningful help for depression as an illness
8. Questionable usefulness of the treatments offered by the psychiatrists e.g. talking and running therapy
9. Presentation of a milder picture of depression and other psychiatric illnesses than migrants are actually experiencing

The focus group discussion was audio taped and transcribed for analysis. The data are presented along with the relevant conceptual categories developed to guide the process of analysis (see the table below).

*Clinical Charts and matched diagnosis*

The following two methods were proposed to be employed in the original study. The very late discovery that there are no Ethiopian migrant patients in all of the six care giving psychiatric teams (after counting long on the formal words assuredly given by the administrative psychiatric
staff about the presence of the target group in the clinic as patients) made it necessary to drop the techniques. With the firm belief that it would greatly help the complete documentation of the ethnographic process, the rationale and systematic design of the proposed but unused methodology are briefly presented.

Clinical charts

Clinical charts refer to case histories and progress notes by the psychiatrists together with results on mental status tests and other diagnostic examinations. These clinical charts were supposed to be well-suited for the purpose of enriching the ethnographic data obtained from informants and cross-checking its quality and serving as a source to get access to and look for the clinician’s interpretations or difficulties to interpret the presented symptoms. By so doing, it was planned that source and informant triangulation can be applied. Permission to access this source of data was almost granted formally from psychiatrists and assurance for the confidentiality of the information and utmost care to use them anonymously and to keep them confidential throughout was also given. Nevertheless, this method, it was anticipated, could have one limitation i.e. the translation of case records that are documented in Dutch into English. This challenge and limitation, it was planned, can be offset by getting the charts translated by professional translators who work with the psychiatric unit. The translated versions, it was also designed, will be checked for accuracy by the academic advisor who is overseeing and supervising the research.

Matched Diagnosis

This strategy was supposed to be used to look into the cultural variations in the manifestation and expression of non-psychotic depressive symptoms among informants and other selected Dutch patients who underwent similar diagnosis procedures and shared same diagnostic labels. This was believed to help to find out whether there are differential diagnostic procedures applied and to inquire further why that is done so and how.
Data analysis

Primarily two qualitative methods of data analysis were used to synthesize, categorize and make meaning out of the collected and culturally produced data. Alongside the process of data collection, the task of transcribing recorded interviews got the continuous validity check on inter and intrainformant information instilled. The time shortage was an impeding factor not to take more informants, keep on doing interviews till theoretical saturation is achieved and work towards synthesizing the data. To establish a web of patterns in the collected and produced data, cross-tabulated matrices with social and cultural variables/categories that emerged from the interviews against the ways in which the illness is conceptualized, experienced, expressed and treated are utilized. These categories are not preconstructed but were formed while data collection and production.

Coding scheme and analysis

To facilitate the process of analysis and synthesis of the research data collected, the following scheme was drafted. This guideline was designed after having gone through the first six transcribed interview data with the intent of mapping out the topography and essential analytic categories of the text. Here follows a brief description of the first two parts of the scheme. The scheme is based entirely on alpha variables.

Rationale for categorizing the interview data

The rationale for categorizing the data along with the following categories stems from two sources. First, the general insights derived from the nature of the interview data in terms of the conceptual classification and narration made by the informants themselves served to shape the text along the below mentioned codes. The second and equally important reason is the design of the research project, largely its objectives and focal themes. Even though the breadth of the conceptual categories here appears to be fixed and gross, a more specific breakdown, flexible and refined coding scheme was adopted for the final synthesis through a continuous revision and
updating as new interview data were reviewed and included.

<table>
<thead>
<tr>
<th>CODE</th>
<th>CODE NAME</th>
<th>CODE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PD</td>
<td>Personal Details</td>
<td>Age, sex, religion, citizenship status, ethnic group, length of stay, brief life history</td>
</tr>
<tr>
<td>DMI</td>
<td>Views on mental illness</td>
<td>Encompasses the meaning, types of mental disorders, contextual antecedent-consequent links and social perception; ethnopsychological beliefs</td>
</tr>
<tr>
<td>DMD</td>
<td>Definition and meaning of depression</td>
<td>Conceptualization of depression as a form of mental disorder; thoughts/cognition, feelings/affect, actions associated with it (its phenomenology); signs and symptoms/identification criteria</td>
</tr>
<tr>
<td>LTD</td>
<td>Local terms for depression</td>
<td>Contextual definition of and ethnopsychiatric premises behind supposedly equivalent or nearly equivalent local terms and phrases for depression</td>
</tr>
<tr>
<td>GAD</td>
<td>General etiology of depression</td>
<td>Causative and precipitating factors for depressive illness</td>
</tr>
<tr>
<td>SAD</td>
<td>Specific etiology for depression</td>
<td>Causative factors and precipitating conditions pertaining to Ethiopian migrants in Holland</td>
</tr>
<tr>
<td>CON</td>
<td>The depressed vis-à-vis the non-depressed</td>
<td>Differences and similarities in the behaviors of people with and without depressive illness</td>
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<tr>
<td>DFD</td>
<td>Depression as a functional disorder/ sick role</td>
<td>Views on depression as having intended end and ulterior social functions</td>
</tr>
<tr>
<td>TOD</td>
<td>Types of depression</td>
<td>Degree and forms of depressive disorder</td>
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<tr>
<td>BBD</td>
<td>Blame for being depressed</td>
<td>External attribution of responsibility in light of the occurrence and development of depressive illness</td>
</tr>
<tr>
<td>ROM</td>
<td>Response of migrants</td>
<td>Reaction and perception of the Ethiopian migrant community toward depression as a disorder and the depressed</td>
</tr>
<tr>
<td>IPD</td>
<td>Individual profile and depression</td>
<td>Social skills, personality, sex, social status, job, color, background and others</td>
</tr>
<tr>
<td>SOD</td>
<td>Status of depression</td>
<td>Status of depression as a mental disorder, reasons for why depression is and is not a disease among the migrant community</td>
</tr>
<tr>
<td>HSD</td>
<td>Help seeking for depression</td>
<td>The process and rationale for help seeking including self care and professional help;</td>
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<tr>
<td>RSH</td>
<td>Reason for not seeking help</td>
<td>The reasons why psychiatric help is not sought by the migrant community for depression</td>
</tr>
<tr>
<td>IDS</td>
<td>Acculturation</td>
<td>Assimilation, alteration, communication and associated problems in the interaction between and among the migrant community, the Dutch society, the Dutch policy, health system and</td>
</tr>
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</table>
Furthermore, componential analysis of the language elements used to speak about and express illness experience is applied. Its application is also extended, when applicable, to see what cognitive rationale the informants have when they use local terms to describe their mental state in relation with depressive illness. To illustrate constantly generated ideas, actual verbatim quotes together with dialogues are used in the data presentation for depicting interlinks and meaningful patterns.

**Anticipated problems**

Mental illness in general in the Ethiopian context is a stigmatized phenomenon and taboo is associated with seeking professional or non-professional help to psychological problems. In light of this, it was anticipated that getting enough voluntary informants and afterwards interviewing them on sensitive issues was anticipated to be difficult, if not impossible, demanding and time taking. Besides, symptoms associated with depression can be significant impediments to data collection. Low motivation, missing appointments, and dropping out, in consequence, could seriously challenge the fieldwork. In close connection, information obtained from this group of patients may understandably have problematic reliability.

**Methodological reflection and field experiences**

Lessons learned from access negotiations and the actual fieldwork experience and some remarks on the methods of data collection and analysis are discussed in this section. The problem of obtaining access to the necessary field data either from individuals or from institutions appears as one of the first challenges to take up in ethnographic work. The proposal of the original study was first written based on the interest of the researcher in cross-cultural mental health issues and the reported challenges faced by the Dutch psychiatric care system to handle and provide culturally sensitive and
clinically effective diagnosis and treatment to the increasing migrant patient population. Later, the research design on the sociocultural dimensions of the diagnosis and treatment of Ethiopian migrants with depressive illness at AMC was developed after a preliminary interview with the Head of the psychiatric unit in the Amsterdam Medical Center who confirmed the presence of Ethiopian patients and the existence of the problem to be studied. The initial formal link with the psychiatric unit was made through one of the researcher’s professors and this social networking has made the consecutive access negotiation process much easier and less time-taking. It was learnt that the social network approach is effective at least to establish initial working relationship with gatekeepers. Apart from drawing on this interpersonal resource, the access negotiation was further facilitated when the head of the psychiatric unit, the gatekeeper who can grant or withhold access into the hospital, came to know that the objectives of the proposed research revolved around some of the important concerns of the institution itself. Thus, the gatekeeping role of the head of the unit gradually came to be extended to a sponsoring role in that benefits in terms of throwing light on social and cultural issues involved in the diagnosis and treatment of Ethiopian migrant patients with non-psychotic depression could be obtained from the research.

More importantly, the ethnographer’s identity as an Ethiopian and intentions as a graduate student created the positive impression that the research was an academic exercise, no more than a learning experience, and that the study could have potential benefits from being conducted on Ethiopian migrants by a member of their culture. An expert role was then ascribed to the researcher and the outcome of the research enterprise was seen in a very positive shade. Not so much concern was observed on the gatekeepers as to what picture the ethnographer will draw at the end of the study about the psychiatric clinics– their internal organization, workings, efficiency, and other sensitive issues. All the four elements combined led the access negotiation process to a second level where individual psychiatrists should be informed about the purpose of the research before they allow any investigation to be made on their clients. This took some time and finally it was suggested from the head of the unit that the researcher should approach the six team leaders of psychiatric care giving groups that work in the south eastern part of Amsterdam. After having a discussion about the proposed research, the team leaders took very interest in work but reported that there are no Ethiopian patients in the teams. This brought the proposed study to a dead end. Later, it was learnt
from the team leaders that they were not in good and close relationship with the administration of the psychiatric unit and that the unit has very limited information about what goes on in the clinics and a loose organizational link. From this field experience, a cognizance was taken as to the limited reliance that should be made on the information obtained about the activities of subordinate organizational units from higher authorities who have the power to grant or refuse access into an institution. Thus, knowledge about the condition and strength of the structural relations between higher administrative authorities and units that work under them and simultaneous attempts to collect relevant information and to get access at different administrative levels are crucially important for successful fieldwork.

Fernando notes that defining the boundaries of a cultural group is one of the many difficulties that accompany transcultural research. [6] This problem was evident in the selection of research informants for this study and the efforts to homogenize the sample from the target group. The boundaries of the cultural group studied, much better called a national group, in terms of cultural characteristics, are difficult to delineate for the apparent reason that informants in that category do not belong to one ethnic group with common sociohistorical background, do not speak same language, are from various geographical parts of the country and hence uphold different belief and value systems. Due to this, the author constantly refrains from making categorically and ecologically fallacious general and conclusive statements about Ethiopians in general as far as the investigated issues are concerned.

Using snowball sampling as a technique and limited social network, informants were selected for interviews. Quite a number of potential informants appeared cooperative in linking me up with other informants but were not willing to be interviewed themselves. The reasons they gave for this were either that they know nothing about depression or have never felt depressed or know no Ethiopian migrant with depressive illness. There were also some people who felt seriously offended just by the very formal inquiry as to whether they could participate in the research and whether they are voluntary to share their views, opinions and experiences about depressive illness in themselves or in other Ethiopian migrants. Some were even shocked and went to the extent of rejecting the request and advising me to change my research topic, saying that it is futile to study depressive
illness among the Habesha. During interviews, three informants remarked and consistently made me aware that they are just telling about others’ experience of depression, not theirs at all. This definitely showed that depressive illness is a stigmatized problem among the migrant community.

Some informants who were illegal refugees, asylum seekers and even those legal residents with Dutch nationality were very curious about the purpose of the research and the reason why they were particularly chosen as participants. They were as a result uneasy and a bit restrained to give their consent to take part in the study and to be interviewed. Besides, they chose their name and personal details be kept anonymous in the study. This issue had implications for the amount and nature of data collected in the study. Furthermore, the time of the research data collection was a “sensitive period” to establish and maintain initial contact with informants since many of the potential informants were either on summer vacation or were preparing for the final examination of the third trimester. This affected the length of the individual interview time, frequency of appointments and resulted in the delay of the completion of data collection. In sum, the sensitivity of the issue of depressive illness, the stigma associated with it, the time of the research, the legal condition [citizenship status] of the informant are important aspects that played significant roles in the data collection process.

The critical significance of the age group and sex of the ethnographer in establishing trusted contact and interviewing informants on the topics of investigation is observed during the conduct of the study. This happened in a couple of occasions where the researcher had to explain the whole purpose of the study and seek the willingness of two women to participate in the research. These two women were far older than the researcher and found it difficult to give their words and share their very private personal information with a young man who could be one of their sons, though they were positive to co-operate with the researcher. It is believed that age group- and sex matching with potential participants would facilitate the preliminary rapport and trust establishment for later data collection in the field.
Chapter Three

III. Presentation and Analysis of Field Data

Introduction

In this chapter, the anthropological field data obtained and ethnographically produced during interviews and conversations are presented and discussed along the study objectives that revolve around the conceptualization of depressive illness set out at the beginning. These include: the meaning of mental illness, the place and understanding of depressive illness, contextualized description of local terms and phrases used to communicate depressive illness, its perceived causes and manifestations, and health seeking behavior for depressive illness. As emphasized in anthropology, attention has been paid to the description, classification and interpretation of depressive illness on the basis of evaluative judgments of informants adhering to some form of cognitive and contextualized view of emotions and the stories informants told about their and other migrants' distressing lives. Apart from the intended focus of the research, some relevant themes have emerged from the interviews and have been analyzed and included in the related sections.

Each focal area was broken down to a set of representative topics that duly address the central theme. Loosely constructed discussion topics were used during the interviews [see Appendix B]. Continuous updating and changes on the topics have been made during the data collection phase. Concerning the use of psychiatric services provided by both inpatient and outpatient clinics, a small group discussion was organized with three psychiatrists from the Amsterdam Medical Center to get their perspective on the reasons why Ethiopian migrants make less use of the services.

Before directly moving to the analysis section, few points should be made clear. First, in line with the purpose of the study, Amharic [the official language of Ethiopia and the language of data collection] terms have been frequently used with extensive contextual definition to ensure a full grasp of the conceptualization of depressive illness among Ethiopian migrants. Second, the
context-specific use of the concept of illness and disease is not strictly in line with the way the concepts are used in anthropological literature. Thus, they are written (mostly illness) in italics in places where it is used in a different sense e.g. in direct quotations and comparison of the conceptualization with psychiatric nosology. This note also applies to the use of the label depression in that the word has been used when the informants themselves applied the same English term during conversation and when otherwise the phrase depressive illness has been used. Note that the phrase depressive illness is used in line with the conceptual picture drawn in the section on the meaning and definition of depression. Giving it a handy and simple definition here at the beginning is entirely impossible. Third, as pointed out in Chapter II, the informants, having come from various age, social, cultural groups and educational brackets, had a wide array of understanding and conceptualization of depressive illness opinions and reactions to many of the interview topics. The presentation in this chapter might give the wrong impression that the results [the beliefs, the symptom complexes, the local terms, help seeking behavior, etc.] of the data synthesis in the paper are characteristic, widely agreed upon and commonly held among the Ethiopian migrant community in Holland. Last but not least, the depression-related symptom complexes are purely synthetic developments. They are not pre-existing and only came to have their existence after the analysis has been done and should be seen as hermeneutic tools.

Views on mental illness

To treat the subject of investigation i.e. depression broadly, a general inquiry of the essence and conceptualization of mental illness was made during all interview sessions and informal contacts. Responses from elaborate and deep to brief and general have been obtained. Some of the informants gave a definition of the concept of mental illness by drawing on its characteristics/manifestations and others gave essential definition using features that transpire and are evident or inherent in many known forms of mental disorders. The following excerpt is taken from a definition of mental illness given by Lubah, a young computer science student in his late twenties. He said:
“I see it [mental illness] as a misconfigured state of mind or mental functions including the complications and illness this entails...the disordered function of brain nerves when they are overloaded due to various factors—hereditary, personal, environmental or cultural circumstances...The dysfunction can affect your bodily conditions or vice versa.”

From this excerpt and from the discussions we have, Lubah conceptualizes the mind as having different parts, each with its distinctive functions. He also thinks mental illness occurs when something goes wrong in its configuration, in the functional arrangement of the different parts either due to the failure of some in executing their functions (i.e. becoming dysfunctional) or in working together with others. As a computer science student, Lubah believes mental configuration is more or less similar to the ways by which a computer system is set up i.e. an assembly of components that together form a logical physical system. Besides, overload by which he meant psychological stress, social pressure, time pressure, conflict and insecurity that go beyond the bearing limits can render the brain nerves non-functional. Thus, mental illness is seen both as a state/condition including the diverse consequences it brings on the individual as a person and as a social being. It is interesting to note here that the distinctions made between the concept of disease as a biological anomaly and illness as a socially and culturally constructed experience of the disease are merged and viewed as being one. The hereditary factors in terms of determining the functional capacity of the brain nerves and configuration patterns play a role in the occurrence of mental illness. This shows the overlap in the conceptualization of mental illnesses with neurological disorders. Tekle-Haimanot notes that the two categories are distinguished when the old Amharic phrase ወርጋጊ: ወንወላል ሐጓ (ye nerve beshita which means “the disease of the nerves”) is distinctively used for neurological disorders and the commonly used phrase as ዋለወርጋጊ: ወንወላል (ye aaemero beshita, that adequately translates mental disease) is applied to mental disorders. Further, he comments how this could potentially affect the choice of the public as to where to seek help i.e. from a neurological clinic or a mental hospital. [30]

Apart from hereditary factors, personal problems and life’s burden, exposures to entirely new/unfamiliar environment to which the individual can in no appropriate way respond adaptively are believed to result in mental illness. Lubah also believes inflexibility and conservative social orientation can cause mental disorder since it impedes any psychological adaptability in the face of a wide array of individual, social, economic, political and environmental
changes. In a similar vein, Lubah firmly holds, from his observation, the belief that a conservative collective outlook and orientation of a society can make it vulnerable to possible mental disorders whose consequences are suffered by all. A good example for this, he said, is poverty-related mental distress and hopelessness. The mental problem, by virtue of being a common incident, assumes a status of normality and is rarely seen as warranting any change. It then gets consolidated through time as an essential part of life which people put in a maxim: to live is to have that mental inconvenience as well.

In no much less direct and sober manner, the way a child is brought up, the way parents deal with the child is also thought to have a potential causative and protective potency for mental illness. When I asked Lubah what his parents had done to him as a child that helped him to keep “mentally healthy”, he narrated:

“ As any Habesha(Ethiopian), I grew up with full protection from my parents, without taking too many responsibilities and without promoting myself. When I started interacting with peers and being part of the outside world, I had to fight for myself... There, I learned how to get by those difficult circumstances...learnt skills from how to get round to things in a smart way to self-expression. I am equipped with those skills.”

Needless to say, Lubah thinks he had not been inculcated by his parents to have adaptive skills; the inadequacy or the lack thereof, he supposes, would contribute to maladjustment and thus to mental illness.

One other informant, a protestant in her mid twenties, who lost her parents as a child, sees mental illness in context as:

“A person is said to have mental disorder when he has chinket (roughly here used to mean anguish, anxiety, or distress. [For its description, see the section on chinket) and merebesh (mental disturbance, instability); when your mind gets preoccupied by thoughts about life, I mean, the overwhelming control of fear of loss, failure, loss of hope, frustrations, worries etc. over your attention and mental resources. This is how I see it. These mental control and possession ( Petersburg: omiof we aemero meyaz) makes people vulnerable to mental disorder. Other than this, organic causes such as brain lesion and tumor can bring mental disorder. But most often what causes psychiatric
disorder...madness... among the Habeshas is chinket. In our culture, organic reasons are not attributed as causes.”

Full-blown preoccupation of the mind by negative experiences such as fear, emotional and economic insecurity, loss, deep worry, failure, hopelessness, social conflicts are believed to disturb the harmony of the mind. When these experiences get intense and stay long, it is likely for the individual to develop some mental pathology. They are only seen as precipitating conditions that increase susceptibility to mental illness. Though not clearly shown but believed not to have prominent causative status as the former set of experiences, biological causes are also pointed at as factors involved in the causation of mental pathology. In her definition, this informant takes chinket as one of the causes of depression that could by itself be seen as a complex of pathological psychiatric and psychological symptoms.

Mama, a married middle-aged man, has a different conception of mental illness. He conceptualizes mental condition/state as existing in a line, in a continuum where the two ends of the line represent mental health and mental disorder. What lies in between is not pathological, though it is phenomenologically different from what people experience when they are in good mental health. Nor is it a healthy mental state. Mental problems like anxiety, phobia, or depression lie in the middle of the continuum and they can be managed well by the activities and efforts of the individual. It is only when a person is completely frenzied, out of reality and mentally cut-off that he is said to have mental disorder. Besides, the fact that the individual under question cannot do anything more to help his situation and is desperately in need of external support indicates that the person has some kind of mental pathology. In Mama’s conceptualization, a person is either hundred percent all right or mad. A less formal Amharic word for madness, which is sometimes applied to refer to mental disorder is እብিত መት. This word is often used both positively and negatively to imply an extraordinary condition as used in (ebid yahilal—exceedingly enormous or huge) or እብিত ከላይ መት (ebid yale migib—extraordinarily spiced up and delicious food). This word seems to be at the end of one of the sides in the Line Analogy made by Mama and appears to point to the extraordinary deviation of the individual’s behavior from the norm.
It is when there is noticeable impaired psychological and social functioning of an individual that the person is suspected to have a mental disorder. If otherwise, it is less likely for the person to be labeled as mentally ill. This view is shared by all the informants. The definitions given by other informants are fragmented and could not be categorized as the others. However, the characteristics and markers of mental disorders told by informants are also indicated in the findings of a key informant study in Butajira, a rural town in southern Ethiopia as perceived symptoms of mental disorder. [31] The four markers that considerably overlap are described here.

1. **Destructiveness**  The display of very violent anti-social behavior like throwing stones on people, hitting/beating, chasing and threatening to kill or attack with no apparent reason, breaking house properties, acting aggressive on inanimate objects, harming oneself etc.

2. **Nakedness**  Walking naked in public places.

3. **Talking aloud while alone**  Thinking out loud, speaking with oneself aloud (often shows deep preoccupation with the matter talked aloud), talking nonsense, murmuring something incomprehensible and incoherent.

4. **Self neglect** General neglect of oneself, carelessness to ones looks, lack of personal grooming, hygiene, [as compared to the person used to do earlier], very low social inhibition, aimlessness, loss of motivation usually following a failure or a series of failures.

None but going naked on the street is often solely taken as an indicator/a symptom of mental illness. Even then, the labeling depends on other factors such as sex, age, the setting and preceding circumstances. Consideration of who went naked, was destructive, talked aloud alone, when, where are of importance. What was striking in the effort to understand what causes mental illnesses in the eyes of informants is that religious explanations that could have dominated had the interviews been done with people in the country of origin were missing or marginally touched upon.
Conceptualization of depression: Some dialogues

Essence and phenomenological status of depression

As noted by many anthropologists, it is methodologically inappropriate to use terms like depression in a transcultural investigation of the meanings and symbols associated with it if that same term is not used in a similar linguistic profile and communicative purpose as it is in the language of inquiry. As a more sound and appropriate method, an ethnosemantic interview procedure is suggested to elicit words and phrases that are either equivalent or semantically close to the concept around which the research is to be made. This method was planned to be used in the original study since participants were supposed to be selected Ethiopian migrants with non-psychotic depressive illness. When the target group was changed to Ethiopian migrants in general, it was found necessary to modify the method to the investigation of equivalent local terms, elicitation of the nature and meaning of these terms and enrichment of the description by using real life events instead of generally evoking symptoms of mental illnesses and later categorizing them. Besides, it was attempted to find out the meaning Ethiopian migrants attach with depressive illness, how it is communicated, experienced and reacted to. Though the interviews were done in an attempt to see the individual experience and cultural coloring of depression as a psychological state, flexible analytic efforts have been made to move from what is described by informants to slightly general conceptual categories instead of solely relying and consistently sticking to the otherwise analytic stance.

The results from the interviews indicated that the concept of depression as it is conceptualized in the psychiatric world does not exist but related symptom complexes that significantly overlap with each other and often with depression as a psychiatric disorder have emerged from the data. Narratives of depressive symptoms as accompanying psychological states to other mental or physical problems and with other emotional disorders like anxiety and personality disorders reveal the existence of the symptoms, though not socially and culturally categorized under one disease/illness term like depression. Here follows some dialogues that reveal ideas and concepts from the informal conversations I had with informants about the meaning of depression.
Dialogue 1: Depression is like feeling cold in winter

Researcher: What does depression mean to you? How do you see...define depression?
Mamo: I don't know (laughing). I have never thought about it... Depression is yesimet mechachan \( \text{y} \text{esimet \ mechachan} \) [literally suppression/pressing down of emotions/low mood]. It is being controlled by a particular kind of emotion as if by evil spirit. I do not think there is an exactly matching word for all these depressive experiences in Amharic. Dibirt, which you may call depression, is a yesimet mechachan state. But medebet ceases to preoccupy the person after a short period... It immediately passes out where as dibirt lasts longer and dwells on the person seriously.

Researcher: How do you characterize a person with depression? What symptoms do people with depression exhibit?
Mamo: I know a person who is suffering from depression. She is aloof, remains calm in the middle of a crowd.... You can see and read her suffering from her face. She wants to avoid the group which she is part of at any moment.... She wants to be alone in her bedroom...Her mental state is on the rollercoaster...She is excited, high on the sky once and she is low, on the ground the other time. And she cannot relate to love and joy. She can not mix with people.... She obviously withdraws... She feels low, worthless and tortured inside. Sometimes she is sociable and interactive. Other times, she creases and crumbles you. With her behavior, people get repulsed.

Researcher: (An inquiry into help seeking behavior)
Mamo: To start with, there could be quite many people who suffer from depression and who manage to camouflage it. One thing you should take note of depression is... as such...you see.... George Orwell, in his classic work "Nineteen Eighty-four", wrote that the word "love" was taken out of a dictionary with the intent of disendowing, desensitizing, and neutralizing its expression and the experience that has come to be associated with it. When the word is missing, there is no way to define it. In our country, this could be the case; thus the concept depression appears to be far from neat and remains amorphous. Nonetheless, there are people who experience emotional turmoil inside...Depressive feelings are not signs or symptoms of mental illness at all... we just say we felt down and lonely.

Researcher: Then how do you see them? Are they natural feelings?
Mamo: No, no. That is not only it. You explain it. You could possibly hold your wife as responsible for your mental state at one moment...or you might attribute it to your financial crisis or other everyday problems.... Then, you go to a place where you can get rid of the negative feelings. It is never seen as an illness that warrants medical consultation and check up... It is like wearing warm clothes when it gets freezing cold. There is absolutely nothing abnormal with feeling cold in winter...But when the situation gets out of proportion, the person may seek spiritual help (e.g. holy water and prayer) and medical help form the hospital.

From the dialogue, the informant conceives depression as an psychological state a person experiences, literally, when there is a tight compression/pressing down of emotions [lowering of mood, ye simet mechachan \( \text{y} \text{esimet \ mechachan} \)] resulting from social pressures and negative experiences. He also distinguishes two forms of depressive experience by emphasizing the duration and severity of the experience. The longer and the more serious type is labeled as dibirt and the...
other type as medebet.[see for discussion of the terms in Symptom Complexes section] Besides, there is a subtle implication in his definition that there is an involvement of external agent, be it supernatural or immediate social agents in the causation and perpetuation of the emotional experience. On top of warranting the role of these agents, the informants also used the agents as a metaphor to characterize the overwhelming mental ‘occupation’ or ‘possession’ by the emotion per se on the person as a whole being.

Though Mamo believes in the semantic similarities of the content of the English word depression with the connotative and denotative meaning Amharic equivalent terms have, he is of the strong opinion that depression as implied in psychiatry does not exist in the Amharic language. Not only he denies the linguistic representation of the illness by giving Orwellian interpretation, he also contends that the illness category of depression is absent, for “many people have not felt like that for a long time” and hence the symptoms have not been given a collective name like that. By this he meant the whole set of characteristic and defining symptoms of depression as they are communicated in psychiatry are missing because of the phenomenological inexistence of them among ‘Ethiopians’. This does not at all mean that some or all of the depressive symptoms are inexistent but they are organized in a different experiential system [discussed later] and rarely seen as an illness in the ethnopsychiatric system. Far beyond the lack of exactly fitting local term, the very fundamental noteworthy point is the fact that depression (with all the DSM symptoms used to diagnose it) as a conceptual entity is not known. Many of the symptoms characterizing depression in the psychiatric field are seen by informants as non-pathological but only as unusual and unpleasant parts of life experience and hardly point to the necessity of medical help. This goes to the extent of contending that depression is not a psychiatric disorder; it is just a manifestation of life problems, a mirror reflection that the person is having hardships in life.

Here, it should be seen that organization of symptoms and labeling of an illness stem from its phenomenology and is largely a social artifact. All informants in the study firmly believe in the idea that depression both as an emotional syndrome and as a psychiatric disorder does not exist in the psychological and social world of Ethiopian migrants. Even those depressive symptoms like loss of interest, lethargy and feeling of worthlessness are rarely seen by the migrant informants as
pathological and rather often seen as ‘normal’ responses to some external triggering conditions. Mama has put this in a very short maxim when he said depression is like “feeling cold in winter”. Metaphorically, he likens depression to a physiological response and cold weather to a confluence of individual, social, economic, and political factors to show that depression is a natural response to a concurrence of felt and/or experienced negative, undesirable instances as poverty, unemployment, loss of individual and family social status, social rejection and failure in an attempt to achieve etc.

**Dialogue 2A: Depression as an outcome of low inner capacity, low expectation and valuing oneself as narrow**

**Researcher:** How do you conceptualize depression? How do you understand it?

**Dires:** I can label it in Amharic as chinket. But I feel that I know and better understand depression in English than I do it in Amharic.

**Researcher:** Is chinket an equivalent Amharic term for depression?

**Dires:** No. I don’t think chinket stands for depression. Depression is much more than chinket. Depression is, I think, a result of the incongruence between what you can produce and what you are required to produce in life. I mean...internal capacity and external capacity...social expectations and roles...This creates mental burden on you...This is one...The other thing is...when you have very low expectation for something, when you judge your inner self as narrow...

**Researcher:** What do you mean by narrow?

**Dires:** For instance, you have aspirations, plans, and standards in your life. When you stick to these despite the reality taking a different route, you then find it inconceivable to accept the reality. What I called as valuing yourself as narrow is being one-sided and inflexible in your standards and plans in life and expect life to flow into your ditched stream ...This could also lead to depression.

As discernible from the above dialogue centered on the meaning of the concept depression, this informant perceives his knowledge of depression better in English. He also does not think that the label he gave at first i.e. chinket can not fully stand for depression. In stead he sees depression as a broader illness category that embraces chinket. In a later conversation, he reveals that he knows less of what depression is and what it implies because the concept depression with its psychiatric connotation is alien to Amharic discourse on mental health among Ethiopians. To him, depressive illness is a psychological gap between ones abilities and social expectations. Falling short of expectation and maintaining low expectation for things in life are seen both as causes for depressive illness. Inability to compromise and narrow the gap often by increasing one’s output and contribution up to the expected standard, incapacity to keep oneself flexible and being unable to
adjust to demanding and new conditions could lead to mental overload, mental stress and then to depressive illness. This conception is somehow similar to the Rogerian understanding of mental problems in general and anxiety in particular. This humanistic theory states that anxiety arises when there is incongruence between what one wishes to become [ideal self] and what the person actually is [actual self]. Though this understanding relies on the person’s ambition of who to become, the repertoire is largely derived from the normative standards of the society.

**Dialogue 2B: Allowing oneself to get depressed**

**Researcher:** What other equivalent words/phrases for depression do you know?

**Dires:** Being obsessed... (in English) [Q... in Amharic?]

**Dires:** Medeber... Not medeber. Rasin masdeber... Rasihin masdeber... (allow oneself to get depressed)

**Researcher:** When you say rasin Masdeber, it seems that depression is entirely an individual affair in terms of aetiology. Is that right?

**Dires:** Yes and no. The environment always brings you two options. The environment could either be pro or against depression. From my experience, the environment sometimes offers you a challenging and often stressful situation. In those times, if I am not able to keep myself up with and be flexible as to the condition... rasin asdebrewalehu. (I let myself get depressed or allow myself to get depressed). I get my mind filled with all the negatives from outside. After sometime, I realize that I depressed myself.... When I let things go, make myself bendable, face the things as they are instead of giving my reasons for them and stuffing my mind with negative thoughts. When I face them directly, make myself humble and adjust to the new demands.... Often I speak with my self, reason out, and look at the issues from in and out... these saves you from being depressed.

Preoccupation and obsession with life thoughts, deep worries and feeling of insecurity over a particular event in life like fear of getting dismissed from work and the rejection of request to get a residence permit in Holland among migrants are seen as major causes for depression. On top of his appreciation of the marginal roles of the environment in the causation of depression, Dires puts the individual at the center of the depression scenario. Inflexibility and not being ready to adjust oneself to novel and demanding situations can lead to depressive illness. According to Dires, it appears that depression is a matter of individual competency and psychological uprightness. Thus, when one can not adapt effectively and respond to external expectations and demands appropriately, depression is likely to overwhelm and take control over the mind of the person. In his own words, the person lets depression to take control by getting his mind filled with negative thoughts. Environment has also a little part to play in that it provides people with options; it is where the provoking conditions [life's
problems/ ups and downs] stem and confront the individual. To make a choice and make oneself adaptable is entirely up to the person. If the person cannot stand, face the challenges of life directly and work on them, he ends up being depressed. Another informant, Lubah, who, one among many, shares the same understanding with Dires gave the following as a demonstrative instance of depression in real life.

"...This...what the Dutch here expect from me-their expectations-and my subjective reality-what I know of myself- are very far apart. They perhaps have different views on blacks. They narrow their expectation spectrum, place us in the pigeonhole with characteristics and roles and look forward us to be up to that. Unless you can express and demonstrate yourself, you will end up with in their expectation spectrum. I have three examples. I lived with a Dutch family and worked in two different places. In my times with them, they witnessed a different way of living together with people. They experienced unusual cohesion and love. They came to appreciate and live self-expression since I used to express myself...my good points...in culturally shaped social manners. This not only eased the tension that prevailed as a result of cultural difference-call it signal- between us but also nurtured the relationship among themselves. They enjoyed my presence. Whenever I plan to organize our traditional coffee ceremony, relatives who haven't seen each other for long meet on the occasion. There were people who happen to be present on the coffee ceremony and who had negative and prejudiced views on black people. When they came to see my academic merit, work discipline, personal integrity, they started to revise their prejudiced perception. One of them even told me how happy he would be if I marry his sister. There were also times when I counseled married couples on their problems......"

During our conversation he recollected how he was exposed to a situation i.e. low expectation from Dutch family and friends and the subsequent challenge for him to break that wrong expectation and demonstrate who he was. He believes that he made himself adaptable to that unfavorable social context where he was valued lower than he knows himself. In the above excerpt, it is shown that the informant was able to change his social relationship by working against the low expectation and eventually getting the people change and appreciate the relationship. His self-demonstration and expression, he believes, has kept him free from depressive illness and considers it as one of the protective factors to the illness. Much beyond the case example, the foregoing discussion shows the perceived role of the individual as far as preventing and making significant changes on ones mental state [in a limited sense] brought about by the immediate social factors is critical.
Dialogue III: Depression is loss of mental freedom and loss of happiness

Researcher: What does depression mean to you? What is the equivalent term/phrase for depression in Amharic?

Hibist: It means chinket. That is how we call it in Amharic.

Researcher: How do you explain chinket?

Hibist: When I explain it, it makes you ...you can not work and move. You can not eat and drink (low appetite). You start rasihan metal...

Researcher: What do mean you by rasihan metal?

Hibist: You don’t take care of yourself...do not keep your hygiene...I was once depressed. I could not be the person I used to be. I was not happy (destega alneberkub) It is only when you are happy that you enjoy chatting, eating, dressing up etc. When you lose your freedom of mind, you can’t do all these. You can’t do things that were once enjoyable because the mind conveys a message. It tells you that you have lost something. And when you do not accept that, you start spending most of you time in bed- sleeping, talking alone on the streets, or isolating yourself and avoiding any contact with people. Worse still, there are those who attempt to commit suicide by hanging or taking poisonous drugs/substances.

Researcher: What other signs do people with depression show?

Hibist: Carelessness. They do not show the slightest facial expression conveying happiness. You read less of the feeling of happiness from the face of these people. If there is depression in him, he does not feed well and thus it is most likely that the person loses weight. These are the symptoms.

Researcher: Do you believe that depression takes different forms?.

Hibist: The types depend on the causes. For instance, there is light depression i.e. you get tensed ..stay into it only for a while. If you take me as an example, I have now light depression. After I come to know the results of the test, I will either get more depressed or get back to normal. This means something different. Do you understand me? There is also the ‘irremovable type’ that you can not get rid of. This type leads to self-damaging behavior...its consequences are grave.

Researcher: You are saying that depression takes different forms from person to person. Am I right?

Hibist: Depression is one and the same but the causes differ and it appears differently on different people. It is loss of mental freedom...

Researcher: What is loss of mental freedom?

Hibist: How can I tell it to you? Amharic is sometimes a difficult language. If you are mentally free, it means that you are happy. If your mind is imprisoned, you are depressed. Our mind controls all of our body. Every message to our body is sent from there. When one of our hands is broken, we can get healed. However, if we have some mental disorder, we can not get healed because our mind is the core element. Apart from the difference in the causes and the effect it has on different people, depression is all the same.

In summary, the insights and ideas learnt from the above dialogues about the meaning of depressive illness include: the essential linguistic and experiential inexistence of the concept of depression, the different organization of symptoms of depressive illness, the questionable disease status of depression and the perceived general causes of depressive illness. These topics are discussed in the subsequent sections in detail.
From labels to essence or from essence to labels

The whole system of psychiatric nosology depends on the classification of mental disorders based on their inherent features [affective, thought, personality, organic disorder etc.], characteristics [signs and symptoms] and distinguishing markers [intensity, duration, prognosis and response to drugs]. In psychiatric settings, it comes naturally for the clinical practitioner either to look for the signs and symptoms described in the standard manual on the patients or to try to pigeonhole patients’ experiences in one of the categories from the nosology. This diagnostic process has both inductive and deductive nature in that the clinician can work on signs and symptoms and move diagnostically to clinical labels. Or the practitioner takes a tentative clinical diagnostic label and moves in the process of psychiatric diagnosis to confirm or disconfirm the clinical guess with psychiatric tools and other medical evidences. With the conception that the psychiatric instruments are universally applicable and all embracing, it is hard to find psychiatric experiences from patients that cannot be categorized in the classification system. However, in culturally sensitive diagnosis and research, due attention is given to the social and cultural belief system and more importantly to the psychiatric phenomenological experiences of cultural members of a certain society to arrive at a meaningful understanding of the experience and expression of a particular mental problem and consequently recommend effective treatment in stead of giving precedence to the classification system.

In a similar vein, the cognitive process of moving from the indispensable qualities or inherent characteristics that identify one subject of interest [essence, in this case depression] to a name, a symbol that can collectively stand for all those constituting fundamental components and features of that same subject [label] is no doubt greatly shaped by culture. In anthropological studies that are inherently comparative in nature, it is essential to pay attention to how members of a particular culture organize and label their experiences and see through how this experiential organization and labeling is different from other cultures in stead of imposing a label and trying to find out how that label is experientially conceived, named and used in various social contexts. In this study, ethnosemantic interviews, despite their methodological appropriateness and soundness, are not used
to invoke symptoms of mental problems in general and specifically of affective and affect-related disorders from informants with the purpose of putting them together in an ethnopsychiatric system. A similar approach i.e. an inductive and synthetic move from symptoms to ethnopsychiatric symptom complexes, however, has been applied during analysis to learn how symptoms are organized, socially and culturally constructed by collecting depression-related symptoms and symptom/illness categories from the transcribed interviews without deliberately employing ethnomsemantic interviews to elicit the symptoms from informants. Often times, comparisons have been made with depression as conceptualized in DSM-IV to get a better understanding and synthesis of the field data.

*Depression-related symptom complexes*

Interesting enough, it was learnt from the study that none of the informants has the conceptualization of depression as it is constructed and thought of in western psychiatric discourse. Nevertheless, most of the symptoms including those nine core signs and symptoms as listed in DSM-IV that should be present to define a psychiatric problem as clinical depression were frequently reported. But, the ways in which they were organized, interpreted and reacted to are entirely different and peculiar.

The concept of depression as defined in the western psychiatric discourse is not seen as a mental problem to which medical help should be sought at all as far as the migrant informants are concerned. All informants have a good deal of knowledge and experience with depression as a mental problem since they are living among people who regard it as a disorder. Some informants who had quite adequate awareness of depression as a psychiatric disorder in the western world often compared their conceptualization and understanding of it by frequently referring to the former and showing the basis of their different model of understanding. Despite this, the idea that depression is not a psychiatric disorder was strongly defended by some informants. In stead of verifying the existence of an archetypal concept of depression, four 'illness' categories have emerged from the ethnographic data. Furthermore, somatic symptoms are not reported by informants as being indicative of depressive illness except weight loss and loss of appetite (not increased appetite) that
can not really be labeled as psychosomatic and culturally fashioned ways of expressing emotions. In
close connection, biological factors or biological susceptibility as part of the depression etiology are
not put forward by informants except few citations on the possible impact (as consequence, not as
causes) of depression on physiological processes like digestion and co-occurrence of depression
with illnesses like AIDS and cancer. The latter two are given as types of disease that may be
accompanied by depressive illness, not because there is an underlying pathological link between
them but because of the psychological stress, insecurity, and hopelessness they bring about on the
individual due to their chronic and incurable nature.

This part of the analysis should be read as purely hermeneutic abstraction of the data from its
symbolic context and as an attempt to make general sense of the ideas and experiences of the
Ethiopian migrant informants in view of depressive illness. The symptom complexes apparently
took form as clusters of depressive symptoms during conversations with informants and clearly
emerged as wholes after analysis. Thus, direct and literal use and application of the symptom
complexes is likely to be misleading and erroneous.

In the following paragraphs, the four symptom complexes are presented with their characteristic
features, local terms, and contextual description of the terms together with illness stories.

The chinket complex

This complex of symptoms is a large category in the sense that it contains a number of symptoms
that overlap with the signs and symptoms of depression as outlined in DSM-IV and is a loosely
delineated class, for the symptoms embraced by it are not exhaustive. It was difficult to find perfect
consensus from informants as to the inclusion or exclusion of some symptoms into this category.
Besides, it includes symptoms of other psychiatric disorders. Not all people quite agree what
chinket clearly is and what its markers are. But there is a general consensus among the Ethiopian
migrant informants as to its fundamental features.
Generally, a person is said to have *chinket* when he is distressed, anxious, tensed, strained and does not know what to do about the cause of the *chinket*. Anguish and anxiety are the two closest English words for *chinket*. [Depression is also commonly given as an equivalent]. However, *chinket* does not involve physical pain or suffering at all unless the causative reason for the *chinket* is a physical problem as the English word *anguish* implies. The Latin and the French root of the present English word *anguish* [Latin root *angustia* meaning *tightness* and the French *angustus* meaning *narrow*] together somehow better convey the Amharic meaning of *chinket* and its derivative *mechenek*. The tightness refers to the psychological pressure and the high level of stress induced by the supposed causes for the *chinket* and the narrowness implies the temporary inability of the individual under consideration to handle and get relief from the stress.

It is believed that *chinket* mostly comes about due to untoward event [e.g. dismissal from work], unfavorable situation [e.g. poverty-related problems] or unexpected outcome [e.g. failure in exam or death of loved ones]. In this regard, *chinket* appears close to stress as it is sometimes brought about by life changes and as it demands a considerable amount of mental energy for adjustment. *Chinket* presupposes that the individual has to take action to avert the coming of the unpleasant event, danger, or, if the individual is once in it, to escape from it. Of all, preoccupation with what to do about problems to the partial or complete exclusion of any other issues in life that might lurk around during or after the occurrence of the life stressor is very characteristic with *chinket*. The duration largely depends on the cause and on the level of importance of the source of chinket to the person's psychological survival and life. The loss of control over determining the course of the problem is also critical in influencing its severity. In short, the individual is expected to take measures to curb the danger. The individual's *chinket* over matters that are generally believed not to invoke so much fear and concern and the level of the individual's capacity and real effort to bring a solution to the problem greatly determine the attitude people form on the *chinket* of an individual. Some of the informants think that there are people who get extraordinarily concerned for and preoccupied with the minutest life problem, people who put too much hope and unrealistic optimism on what the future will bring to them and who insist on achieving some goal despite the almost impossible circumstances. These are the people who are thought to have the highest risk of developing *chinket*. 
These people are also said to be more vulnerable than others to ye menfes chinket [游戏操作：悶鬱], a serious form of engrossing chinket that could lead to a state of mental derangement/madness. Here, it is understandable that chinket is seen as a cause for a serious mental disorder, but not as one form of mental illness itself. One informant told:

"...Chinket has actually different forms. A normal, healthy person can have chinket. I am not talking about that. Whatever goes beyond your capacity to psychologically handle it, something you think as having no solution could give rise to madness, or mental illness. It could also lead to life threatening acts."

In addition, chinket is characterized by source-specificity and the individual is seen as one who can do something about to change the condition. Different people are presumed to have different capacity level of handling chinket, concealing its expression, minimizing or bearing its suffering, and bringing an end to it in short time. The term chinket is most commonly used by informants and often seen as a seemingly close illness category for the set of symptoms that make up depression. It also has overlapping symptoms with anxiety disorders.

Presence of well defined and known causes e.g. life stressors as such as unemployment, significant losses and separation from loved ones is a triggering factor. Action is directed towards the supposed sources of chinket in an attempt to reduce its impact on the person or completely wipe it out before it takes effect i.e. overwhelm the person to total incapacity. Chinket may lead to madness [ebidet-psychosis] when it gets more severe and stays long on the person. Some of the symptoms informants said they use to identify a person with chinket as a collective category include:

- A strong sense of having little control over life events
- Feelings of inadequacy and helplessness
- Excessive uneasiness and concern for things
- Insecurity - fear of what is going to happen when one knows there is nothing but little to do to make a difference in the situation [min yihonal/ yimetal yemil sigat]
- Constant preoccupation with the likelihood and consequences of negative life events [be hasab meyaz]
- Inability to experience happiness
• Deep worry and anxiety
• Inability to engage in usual activities like working and studying
• Pessimism [ayihonim bilo maseb]
• Less social interactivity and avoidance behavior
• Weight loss and headache [not often cited]

_Dibirt and Rasin Masdeber 2:4IC?

From the interviews, it came clear that the word _dibirt_ refers to transient, fleeting state of low mood that appeared close in meaning to the “blues” or normal as opposed to clinical depression. Temporary need to stay alone, lack of interest and motivation to do usual activities, aloofness, unsympathetic state of mind, being unusually quite and calm are reported by informants as the characteristic symptoms for _dibirt_. Hibist, while comparing _dibirt_ with _chinket_ said:

“_Dibirt_ occurs when you are idle, fail exams, are ill, or when you can not get what you wanted at one moment. This is not _chinket_. Potential to lead hopelessness and severity makes _chinket_ distinct. _Depression_ stays long, is wide and severe; and it is hard to find end to. But _dibirt_ may be for one day. ...There are thoughts that persist to hover over your mind and there are also some that you put an end to by taking them to action. The first set of thoughts that continue to occupy you insistently leads to deep worries; and pushes you into _chinket_. This scrapes you off your happiness [destahin yigefiha] veers your happiness away whereas _dibirt_ disappears soon. If we take a person who disagreed with his partner on important matters, he most likely feels _dibirt_ afterwards. But he still knows that things would get straight very soon with his partner. They may call each other next day and settle it. Then, experiencing happiness in the relationship resumes.”

From the above quotation, preoccupation with some thought characterizes _dibirt_ as it does _chinket_. The possibility of losing hope in the subject of concern, increased severity and long duration are given as distinguishing markers of _chinket_ from _dibirt_. In addition, inability to experience happiness is indirectly hinted at by Hibist in the case of _dibirt_ that recommences after a while. According to a recently published English-Amharic dictionary, the root of the Amharic word _dibirt_ is _medeber_ that refers to the state of sulleness, silence and loneliness from the feelings of resentment and disappointment. From the informants, a person with _dibirt_ is taking time to work on and psychologically restore the mental state without such feelings by granting oneself temporary
exemption from the engaging activities that have to be performed at that time. This is often done by taking a short sleep or staying silent for a while.

Medebet መሚብተት

This complex of symptoms was not commonly cited by the research informants. It primarily refers to a group of psychological as well as physical symptoms that often occur together and are likely to go off/away soon as opposed to those that last longer. These include lethargy, apathy, tiredness, and drowsiness, feeling as having no energy/capacity. It is a state of having lost energy to move and to talk, being inactive and physically pressed down [mechachan, መሸጋ, መንጴ]. The word is widely used to describe the state one experiences- physical stiffness and lethargy- just after waking up from deep sleep. It is different from dibirt in that physical lethargy is involved in medebet which is not characteristic of dibirt at all.

In the Composite International Diagnostic Interview[Amharic Version], the words medebet መሚብተት, dibit ሲብተት [a less commonly used word for the state of medebet] and debach ዱካት [a term for triggering conditions to medebet or anything that renders lethargic e.g. cold, rainy season, deep sleep] have been used throughout the interview guide in two ways that carry different meanings. [32]

1. In questions from A34-A38, dibit has been used to refer to depression as a psychiatric disorder. The following item, which is taken from the Diagnostic Interview Guide, shows the point.

A38. In those two years of depression, have you had unusually increased appetite? [No, Yes] [p.8]

2. The word medebet is also used in the same document as a symptom of depression, with similar meaning as obtained from informants of this study.
In short, it is shown first that the meanings attached to the same term *dibit* among informants and in the diagnostic instrument are different. Second, it is known from the study informants that *medebet* is a combination of symptoms, not a single symptom.

**The rasin mettal complex**

This complex was described as one of the distinguishing markers of mental illness at the beginning of the chapter. It refers to a spectrum of self-neglect and abandonment behaviors that come about when the individual has strong feelings of total hopelessness and worthlessness. *Rasin mettal* is regarded as the result of many failures in valued areas of life in the past and the loss of hope in mobilizing individual efforts to bring a change in the present condition or to effect an end to the problem. Furthermore, *rasin mettal* is thought to be a personal weakness in that the person is not able to withstand the challenges of life and did not come out as a winner. It is said that a person happens to have *rasin mettal* when he loses the game of life after having tried for long and when the person thinks that he is a cipher, unwanted and unimportant. Whether he lives or goes away, he also believes that it is all the same for him and for all.

When one loses hope, he never cares if he has to die now and about what is to come next in life because of high dispiritedness and despondency; this is believed to result in lack of personal hygiene and low social inhibition. Developing an attitude that nothing will get any better in life and having no purpose in life [aimlessness] are frequently given as features of *rasin mettal*. Losing hope is seen as the last and serious stage of *chinket*. When the idea of getting a solution to the source of *chinket* is no longer entertained and is given up completely, hopelessness takes over, taking away the individual’s envision for tomorrow and concern for social expectations. From the interviews, it
often times appeared that hopelessness is seen as being both the cause for [one of the many precipitating factors] and consequence of chinket. The condition of rasin mettal is not seen as irreversible state but is presumed to get better if the individual starts to realize that the pessimistic beliefs about the present and the future are wrong and that abandonment of them is necessary.

Present inability to take care of oneself, unhappiness [inability to enjoy previously pleasant activities] and conviction that the person would never in the future be able to regain all these capacities and live life fully like others are believed to be prominent markers of the label rasin mettal. A former remark on the loose nature of all the symptom complexes holds true for rasin mettal as well.

Most importantly, there is a tendency among people to hide their depressive feelings for the stigma and thus it becomes very difficult to detect and diagnose depressive illness. When asked how one could identify a person with depressive illness, Meseret said:

“The first visible sign is when the person has communication problems. Second, he will have closed facial expression...It is hard to read feelings from his face. Third, since the person does not want his being depressed known, he denies his experience to others in the face of visible signs. Not to be judged, he protects himself. There are people who say they feel all right after you cut their ears off. They can camouflage their inner feelings...they smile while they feel deeply sad inside. From their words, behaviors and motives, you can see that they are depressed...”

Characteristics of depressive illness

A. Depression as an individual responsibility

Most of the informants are inclined to think that the causation and management of depression as described in the above section on symptom complexes is an individual responsibility. Lacking self control such as the ability to make a choice, the ability to set realistic life goals and ways of achieving them, the capacity to shoulder responsibility, and a low level of bearing/withstanding capacity for life’s hardships constitute a set of individual factors that work toward the onset of depression. What is more, lack of self help and social skills like finding a way out once the person is
in a problem and good management of interpersonal affairs are thought to be up to the individual to make a change on them and influence the likelihood of depressive illness. The positivist notion that clinical depression is a neurobiological disorder/medical disease which is fundamentally similar to pneumonia or cancer to which all of us have a susceptibility and which one can not get rid of without medical treatment is not acceptable to most of the informants. This does not, however, mean that the individual is taken as an entirely incontestable agent for the cause of depression as one informant pointed to the way the individual is brought up as a protective/predisposing factor. “Stamina...inner strength is very decisive to keep yourself away from depression. Your background/upbringing also helps you to cope with depression.” Explaining what he meant by upbringing, Meseret said:

“The point is ... we are trained to live in one environment, not in others. If you see Iranians and Ethiopians, they have strong cohesion and interdependence. On the contrary, the Dutch are self-centered and have cold attachment to each other. When you deal with them, you may...often sense and naturally interpret this loose tendency to social ties and inwardness as hatred and rejection. They may regard you as if you are one of them and have positive attitude but their expression brings a quite negative and damaging impact on the other person.”

The informant assumes that people who have a particular set of social setting-specific adaptive skills acquired through socialization may not be able to adjust successfully in a different social setting. When these people find it hard to get integrated into the new social system due to real or imagined social rejection and hatred, high vulnerability to depression precipitates since the bearing/adapting capacity turns out to be minimal for the new environment. In addition to the above excerpt, the following quotation vividly reveals this point.

“It all depends on what comes to challenge your life. [What do you mean?] I mean if your life is full of ups and downs ... hardships... sometimes one may face challenges that can easily be overcome. But these easy-to-get-by challenges could be very insurmountable to some people. People have different levels of capacities. Some are weak. Why do some people bear loss of loved ones? Because they are capable and strong. Their inner self immediately says, “life should go on” despite the loss and starts to look for something that can replace their loved ones. They find something that can compensate what they used to get from their loved ones. Some say no and take a dark route and hold inflexible thoughts and attitudes. These people have a view that loss and unmet/aborted life goals are irreplaceable...and they take this so hard.... But one has to decide his way and what he does determines what feelings he will experience.” [Abeba]
Abeba here made a link between possession of different levels of individual capacities and proneness to depression. She thinks some people are more susceptible to depression because they lack psychological strength and she ascribes a significant role to the individual in the determination of feelings through what one does. The psychological strength is associated with the perception of negative life events and locus of control. Inability to appropriately attribute the happenings in life and mobilizing efforts to positively influence their change is thought to render the individual more prone to depressive illness. Meseret and Kidist express their beliefs on the same point in the following manner.

At times, the causative problem could be of low magnitude and yet the person may lose the game and fall prey to depression. This happens when the person has low enduring capacity. [Kidist]

Depression is attributed to one’s incapacity to hold self-responsibility, inability to keep oneself ready for the unexpected and for life’s challenges, and low self-insight. In our culture, there is no way of defining ourselves as vulnerable to this problem ...there is no way...except to admit that I am weak and neurotic. There is no way of describing our depressed emotions in a way that other people accept us as such...”[Meseret]

It is worth noting from what Meseret said that describing ones psychological situation as depressed is not a readily acceptable social behavior in that the person does not feel free to express his/her depressed feelings to others. To sum up, the development and cessation of depressive symptoms are seen to be in the individual’s domain. This view was still upheld and defended as a fact when external pressures and factors that are beyond control are given as causes/precipitators of depression. There is a belief among informants that no other agent that can do a better job at paving a way to the causation and management of depressive illness than the individual.

B. Depressive symptoms as characters/personality traits

Some persistent depressive symptoms such as withdrawal and lack of interest to mix with people are sometimes treated as characters/traits, not as signals of some kind of mental distress. Characters/traits are defined here as distinguishing psychological features of a person, those that constitute who the person is. Symptoms that are often seen as natural character traits are isolation...
and lethargy [interpreted as ‘laziness’ or ‘tardiness’]. This was found to be a common view among informants.

The author, as a student of psychology and a short-time student counselor in a practicum course, knew people who display the DSM-IV-listed symptoms of depression and who never acknowledged that they are suffering from some kind of psychological problems. A close friend, then 18, a high school graduate, thoughtful and bright, was seriously suffering from most of the depressive symptoms for more than three years (This would have possibly made him clinically labeled as dysthemic, had he been to a helping professional). He was severely lethargic, had insomnia and incredibly low appetite. It was rare to see him smiling, chatting and mixing with people. He almost always spent time on the bed either sleeping or listening to music. What is more, he hardly had interest to see and be with relatives. Never did he stay at home when folks come to pay a visit to his family. If he is in case at home, he would in no time get out through the back door only to appear after they have left. His folks did not know that he was having a mental distress.

His family negatively interpreted his behaviors [symptoms]. They used to see him as lazy, tardy, disrespectful, and even as a misanthrope just because he was slow and often times unwilling and disinterested to observe social norms. He was also treated as rebellious because he was slack to carry out parental commands and acted aggressively when he was told that he was doing the tasks so sluggishly. Besides, the family knowing the fact that he was entirely a different person few years ago regarded him as having an introvert, a very calm personality. The change in behavior could have probably been caused, as his parent guessed, by the failure of the son to pass the matriculation and to join university.

This case history is presented to show that there are quite many instances where depressive symptoms are differently interpreted and reacted to both among migrants here and in the country of origin. Care and/or special treatment are accorded, however, to people who seem to have behaviors and experiences like the boy without recognizing them as characteristics of mental illness. Dires gives the following example.
"I do not think depression is recognized as a form of mental disorder among the general public. They see it as your personality, not as a disease. Until you get completely psychotic and deranged, you are mentally healthy. I have an aunt who, I think, is depressive. Everyone thinks she behaves the way she does because that is the way she naturally is. She receives special care from family members and friends. We help her manage with it. We don't let her alone and feel isolated."

C. Depression as a 'functional' illness

Two interesting concepts i.e. *ayine tila* [አይነ ችል] and *awoko abed* [አውቆ አበድ] came up during an interview with one informant with regard to the functional nature of depressive symptoms. The informant described *ayine tila* as a spiritual possession, a satanic hoodwinking and blindfolding. [*Ayine tila* literally means shadow cast over eyes]. As to the informant, this evil work of Satan often happens to women and compels them to avoid social relationships [isolation] and to show intense dislike to stay with their husbands. Socially, it cuts the woman off from the society. As a result, the woman is no more aware and conscious of what she does and what goes around her. It is thought that it is the *Zar* spirit that controls everything the woman she does.

The *Zar* spirits are believed to have originated in the Garden of Eden. Once, when the Creator [God] came to see the thirty children of Eve, she kept the fifteen bright and beautiful ones in concealment for her fear that God could take them. As a punishment for this, God condemned the hidden children to always remain out of sight and be creatures of the darkness. As a result, these fifteen children, it is believed, hate and envy their siblings on earth who are destined to be creatures of the light. Messing, after his discussion of the *Zar* in Ethiopia, concludes "the 'Zar' is a catchall for many psychological disturbances, ranging from frustrated status ambition to actual mental illness."[33]. In the DSM-IV's cultural axis and annex, *Zar* is briefly described as a culture-bound syndrome in found in Ethiopia.

To substantiate the idea of depression in relation with *Zar* spirits, it was attempted to get the views of other informants with no apparent success. This was mainly because the informants were from the cities and thus know very few things about the institution of *Zar*. This institution is uncommon in urban areas but tend to be observed among people in rural areas in the northern parts of the
country. The very act of giving a personal account of and sharing ones experiences with this institution is not normatively considered as something to be discussed in public with ease and is very unusual.

Extreme apathy and unwillingness to eat, it is believed, indicate that the person is possessed by a Zar spirit (blinded by ayinetila). This person, as a result of being possessed, sits in a particular position in the house for long. In the literature, there is a view that it is women/wives who are neglected and deprived of some marital privileges that appear to be possessed by the evil Zar spirit to get attention and social support. [33] In a nutshell, there is no evidence from this study that depressive symptoms seen on Zar possessed people have or can have functional ends like imposing social control and suing exemption from social roles apart from warranting a possible relation between the Zar cult, depressive illness and functional illness. It is very interesting to explore this issue in light of the anthropological understanding that spirit possession, any illness instance for that matter, could provide a way of rebelling against authority and transgressions of cultural values and norms without punishment since victims are not blamed for their predicament.

Other than this supposedly and loosely established spiritual reason to fall prey to depression with functional ends, there are people who act pretentiously and intentionally in an ostensibly abnormal manner (aqwo abed) for some purpose. With aqwot abed, there is will, purpose and conscious knowledge of the person involved in the communication of the illness to achieve some end. The malingerer who feigns depressive illness usually has social roles, behaviors or responsibility to revert, often in interpersonal affairs, through his acts. The pretentious illness behaviors may serve their intended purpose if others do not figure out that the whole scenario is a social drama with ulterior motives of the main actor. This can actually be seen as one form of conflict management techniques used in societies where other ways of resolving conflicts are either culturally seen as inappropriate or inexistent.
Perceived causes of depressive illness

Without attempting to delineate a concise and neat model of aetiology of depressive illness from informants’ perspective, this broad topic was dealt with during interviews and analysis from two overlapping angles. The first angle taken was grasping what the informants generally think gives way to or causes depressive illness as understood by them. The second more specific focus was on the perceived aetiology of the illness among the Ethiopian migrant community in the Netherlands. This was meant to help find out culture- and migration-related issues that are thought to have causative and precipitating role to depressive illness.

The occurrence of depressive illness is believed to cut across all age groups [except in childhood] and sexes. And it is perceived to be more common among the socially and economically disadvantaged. The next quotation can summarize informants’ views on this.

“...Well, I can not say that small children can have [depression]. It is when they [children] start to know who they are, build self-concept, and have self insight that they begin to experience the difference between depression and happiness. They can only have it when they get older than eight years of age, when they start to think that they are independent and appreciate the taste of life. As I see it, it is hard to say depression is more common in men than women. There is no distinction anyway. It is a FEELING. You understand? It is the one who has soft, delicate and weak feelings that suffers.”

It was hardly possible for the informants to imagine depression that has no real causes. The word real here stands for causative social, physical and psychological factors that can be pointed at and attributed to the causation of depression by the patient. The question informants posed when probed in this direction was: how can a person feel depressed if there are no real reasons for it? In addition, depressive illness is not thought at all to run in families and none acknowledged the neurobiological explanation for depressive illness. Nor do they think vulnerability to develop depression can be inherited from parents. “Depression is not like HIV/AIDS”, one informant said, “it can not get inherited.” Depression, many of the informants believe, results from insecurity and uncertainty over the present and the future, a limbo in the existential sense, and from a failure and a series of failures in life. They see life as a win-lose struggle, a tough game one should get through.
and move on forward. Thus, life demands one to set standards for the struggle [life goals/purpose in
life] and work towards the attainment of the goals. These life goals are presumed to determine the
level of difficulty and the efforts one should exert to come out as a winner and what the person does
influences the level of success in the struggle. One’s success assures one’s existence and promotes
security. When a person has a good insight of what is there to materialize the goals, leaves no stone
unturned to achieve the life goals and has a fairly positive predictable future, it is believed that the
person is least likely to get depression. On the contrary, when one has unclear and unattainable
goals, does not have the necessary resources to realize the goals and misses opportunities, feelings
of uncertainty and guilt and more basically feelings of insecurity over survival and hence low sense
of control over sustenance of life come about. This can be seen as one form of existential neurosis.
In line with this, informants see poverty as a condition that keeps a person in a sustained state of
insecurity and hopelessness and consider it as a potential precipitating condition for depression.

“Back home, poverty- being unable to see to it that your needs are met due to low economic
status and naturally following family problems such as marital instability, divorce, separation,
having deviant children and teenage pregnancy can also lead to depression. Moving downward in the social and economic ladder... loss of status once achieved could cause depression. Anything that leads to shame, guilt, and social embarrassment both to the individual and the family... Here in Holland, problems of this sort are less common... The causes are not the same everywhere.”

Differential causes for Dutch people and for migrants are believed to exist as pointed out above.
Besides, the above quotation indicates social behaviors that lead to shame and guilt such as loss of
achieved social status play a role in the development of depression. On top of poverty and the
consequent poverty-born problems, high and low expectations are supposed to bring about
depression. This is thought to take place in two ways. First, when one holds high hopes and
ambitions in life and is unable to live up to them, it is supposed that the person may fail to attain
them and may be vulnerable to depressed feelings. Second, it is reckoned one could develop
depression when others most notably family expect the person to be up to a certain level and when
the person could not do so. A strong confluence of these two factors on Ethiopian migrants is
supposedly a commonplace happening and creates a double burden on them- a kind of ambivalent
situation where one can not either be up to ones expectations and ambitions [often formed before
migration] and familial demands and expectations [based on the popular ideas of living in a first-
world country]. When the situational demands in Holland appear to be different from what was expected [e.g. serious police supervision, not being allowed to work and move around] and when the migrant is unable to adjust to the demands and expectations [often imagined and unrealistic] from the Dutch society, informants believe it renders the migrant more prone to depressive illness.

When it comes to broader social and political setting, the most commonly lamented reason for depression among Ethiopian migrants is the “exceptionally and deliberately designed” long legal procedures to obtain residence permit in Holland, frequent rejection of applications and legal orders to leave the country. This is seen as the major cause of depressive illness and suicide among Ethiopian migrants in Holland. It is said that almost all migrants except those who came here married to Dutch nationals or to people who already have permit to leave in the Netherlands pass more or less through the same immigration procedures. Some informants see this process as a sacrifice one has to pay to be allowed to live in a sought place outside ones county of origin and thereby could derive a sense of good reason for the suffering the migration entails on their life. Meron, contending that what she says on the immigration procedures can be taken as the voice of all migrants, said:

“What is common here especially among Eritreans and Ethiopians is a long process of getting residence permit. The Police do not take proper action...They reject the application for permit consistently for few years and, at the same time; they assign a local attorney to look through your case and defend you as an asylum seeker. This process takes at least four years and even longer. In the mean time, the applicants start new life here, get married and have children...establish social links, become accustomed to the Dutch way of life, slowly abandon the old cultural values and adopt new values and life style. After five years or so, the Court rejects the case; and the Police accordingly begins to take action in line with the Court’s decision i.e. suspend the allowance, evict the asylum seekers from their residence and demand them to leave the country. They keep you out of the system. This time, the life of the asylum seekers turns dark and hopeless. Sometimes the Police do make mistakes i.e. allowing the seekers stay here with uncertainty and taking a very long and bureaucratic process only to reject the application at the end. They should give decision about the application early before the person settles down. This makes people to live in constant uncertainty... with depression. This is the big problem....”

The role of expectation in the informants’ conceptualization of the causation of depression and the reportedly very bureaucratic, complicated and lengthy legal process to get permission to live in Holland are seen to operate in synchronization. One informant narrated that the very reason
Ethiopian migrants first of all came here hoping that life in Holland would be better than it was at home. When they are denied of residence permit and are ordered to leave, they start to think that they have no where to go. They can not go back home and can not stay in Holland any longer. When they run away from problems, they are again plunged into more grave problems to which easy solution can not be sought. Then, they come to have a view that wherever they go, problems abound and consequently develop pessimism and hopelessness. Besides, they come to lose their sense of importance and gradually begin to develop social hatred. Dires, a legal resident with Dutch nationality, has this to say on how migrants start to experience a feeling of insignificance and hopelessness.

“The Dutch immigration policy on Habeshas is different, unclear, far from uniform and direct. There is also long process and unnecessary mistreatment to get your permit here. It could be because they want to discourage more migrants from seeking refuge here and to systematically incapacitate asylum seekers. That is why they make the legal procedures very long and complicated... to push the migrants to a state of total hopelessness. The other is that...since Ethiopia was never a colony, we are not historically accustomed to see through the subtle ways of dealing with them as others could and we do not have those relational strategies.”

The fact that migrants interpret the long legal process as institutionalized system to control the inflow migrants by purposefully complicating the local immigration policies and procedures and worsening the situation on those who are already in the country has made some informants to think that they are living in a place where their presence is unwelcome and unwanted from which escape is hardly possible. What Dires called relational strategies include submissiveness, suspiciousness and ability to figure out the intentions of the locals, the Police and immigration authorities and he presumes the Ethiopian migrants do not possess them. This last point seems to be an over interpretation and far from reality.

A strong sense of suspiciousness and irrational thoughts developed here in Holland are frequently given as reasons for depressive illness among migrants. As a result of which, migrants tend to be insecure, pessimistic and socially avoidant. Immigration experiences such as creating an entirely made up life histories to give weight to their cases in the court and to obtain a permit, the numerous cross-check interviews and the constant effort by the Police to check on the accuracy of the information both here and back at home make the migrants suspicious of all institutional
requirements, procedures, interviews and any other contact with government organizations. Informants attempt to justify their suspicion by providing instances like the sudden visit of the Police to migrants’ house [allegedly in the absence of the migrant and without prior notice] to see what household items they possess and to check whether migrants could afford to have those properties with the social security they get from the government. There is also a constant fear be expelled or deported on the part of asylum seekers after having spent years in Holland. Their fear and suspiciousness extend even to the reluctance and avoidance of utilizing government services including mental health services in psychiatric hospitals for fear that personal information could leak from the psychiatric staff to the Police. At work place, the effort to execute ones duties, to ascertain and be up to the imagined and allegedly inconsistent expectations from Dutch colleagues, attempts to overcome the language and cultural competence and break up the stereotyped and biased perception of the natives against migrants are cited as sources of stress and are seen to have a cumulative effect in leading to depressive illness. Other than the development of irrational thoughts from negative life experiences, it is also believed that Satan could instill wrong patterns of thinking in people. Meseret, a protestant in religious domination, asserts:

“We are partly responsible for our feelings. The way we live, think obviously has an impact on the type and intensity of our feelings.... You feel tortured and imprisoned by your thoughts. I also think that there is satanic involvement in our negative emotions. Satan feeds evil and irrational thoughts in our mind. If your mind is convinced with and directed by these thoughts, you let yourself get trapped and affectively imprisoned.”[Note the relationship between thoughts and emotions]

Growing without parents or under single parent especially in terms of the deprivation of parental love is believed to have an impact on ones susceptibility to depressive illness. Parental love has a special place in child upbringing and is thought to build up ones sense of worth and self-esteem. The lack of it, it is assumed, deprives the child from the ability to withstand any loss and failure in the future. In addition, the rarity of satisfying social relationships and looseness of social connection is regarded as one of the important things migrants face and have to compensate. This often reportedly happens both among Ethiopian migrants and between migrants and Dutch people. Besides, it is generally supposed to be the hardest to adjust to for new migrants who had been “having warm and strong social relationships” at home. Some of the reasons for the loose
relationships are: the Dutch etiquette of privacy and social behavior, the adoption of it by some migrants and the prejudice and racist views some Dutch have toward migrants. The following quotation shows how the situation looks different among followers of the Protestant Church.

“There is sometimes...blood...inner, invisible, covert feeling and attitude that I am white and he is black. You could see the person [Dutch] smiling to you, his teeth may shine and yet friendship and feeling of oneness/belongingness could be absent. Some have interest to have relationship “unison”[hibiret] with you. In the church, however, the relationship is unusually strong and warm. You see both groups in unity and oneness. They believe that they are all mortals and one in God. Understand? It is only skin color...black and white, nothing else.”

Surprisingly, loneliness- spending too much time in solitary without companionship- is seen as one of the causes of depressive illness. In the time when there is no one to share ones thoughts, plans, worries and all other mental burdens and get social advisement, support and comfort, one has to deal with everything by oneself which is assumed to make the pressures and stresses heavier and more unbearable. The over concern in national politics, the news from home about war, drought and their impact on people and a sense of responsibility and guilt that come following it are no less significant to informants in their contribution to stress and consequently to depressive illness.

Help seeking for depression

In this section, the strategies migrants employ to seek help for their depressive illness are discussed. Invoked by the dead end of the original study [i.e. unavailability of Ethiopian depressive patients in psychiatric outpatient clinics], interview inquiries were made to find out why migrants do not find their way to the clinics seeking help. Quite interesting explanations have been uncovered not only for the low rate of service use for depressive illnesses but also for the reported less utilization of psychiatric services in general. One of the team leaders of the six psychiatric care giving groups at de Meren from his observation while he was in Ethiopia and his acquaintance with some migrants here in Holland reasoned that the low utilization of psychiatric services for depressive illness is largely because “Ethiopians have a high level of threshold for depression”[Personal communication]. In an inquiry as to whether informants agree to the psychiatrist’s speculation, it was found that the speculation is generally acceptable but the threshold-the psychological point at
which *depressive illness* is experienced— is very much attached to the individuals bearing capacity, irrespective to the potency of the causative/precipitating factor and the speculative statement can not be applicable to Ethiopians as a group.

Participants of the study as noted earlier see *depressive illness* as an inevitable problem in life, but not as a mental disease. In addition, there is an appreciation of depressive illness as having one form but multiple causes and varying degrees of manifestations [magnitude] on different people. The magnitude is often seen as a function of the psychological enduring capacity of the individual. The most frequently told attempt to handle *depressive illness* is sharing the accompanying feelings and its discerned causes and discussing the way out with trusted friends and very close folks. This is often done when the individual has tried all possible ways from reading books on the matter to praying and when fails to bring an end to the depressive experience. In this regard, Lubah said migrants would resort to:

"...telling it[depressive experience] to their confidant. Before they give in, they will try all possible self-healing techniques—by making themselves flexible, expressive, by praying and using all methods that they think are helpful. Once you are labeled by others as depressive, it is hard to get out. Sharing what and how you feel with people is very pragmatic and invaluable. You may get advice and ideas as to how people who had gone through similar experiences managed to deal with it."

Note the "self healing" attempts Lubah thinks migrants would do if they find themselves with *depressive illness*. This is not conspicuously unusual but rather common among informants inasmuch as they think that the problem (i.e. depressive illness) is their own problem, not requiring others to help them solve it. Of all self-healing techniques, participants have a good appreciation for the therapeutic value of praying. Meseret, who claims that he can never fall prey to depression, said praying gives hope and hope works against depression. He affirmed "many people back at home go to church when they get depressed and communicate what they experience with God. Since they have deep faith in praying, they get out of depression very soon. Even if I live here, what I, as a Christian, have come to realize and up hold, is there is always a being that you can count on. This is what kept me free of depression. People get depressed when they lose what they relied on. Fortunately, you do not lose God. And this helps. If you think that there is someone to fill gaps in your life, you never get trapped.” As part of self-care, spiritual efforts are also directed to ward off
depressive illness. It is only when the self-care turns out to be taking nowhere that people would consider sharing their problem to significant people. Some people try to reduce their depressive symptoms through alcohol or other mood-altering drugs like khat (Chat), knowing that the drugs can only provide temporary relief and will eventually complicate the illness. No more detailed information could be obtained in this regard since depressive illness is stigmatized and inquiries on self care at individual level were taken so personally and informants could not distanciate themselves to be able to respond.

Moving one level higher to professional mental health care, it was found from conversations with the migrant informants that the use of psychiatric services is very rare for depressive illness. Apart from the belief that depression is not a disorder, which could obviously hinder migrants from using psychiatric services, other reasons are discussed in the next section.

Reasons for not seeking help from psychiatric clinics

There is an acknowledgement of the minimal utilization of psychiatric services for depressive illness among migrants; most of them do not consult health care professionals for mental problems like depression. From informants, it also appeared that this low tendency to visit psychiatric hospital and clinics for depressive illness holds true for health seeking behavior back at home. This might be due to the wide belief back in the country of origin that mental problems are often caused by evil spirits and hence treatment should address to that. Surprising enough, no such reasons are given to the low utilization of psychiatric services by migrants here in Holland.

A recurrence of the crude idea that the psychology of Ethiopians is quite different from the psychology of others and thus the dissection and study of it does not lend itself easily to others and demands an Ethiopian was noted. This, however, was found to be more general to explore in relation with the topics of investigation. In a similar direction, some migrants maintain that depression is medically incurable but individually solvable and see its causes as potentially unknowable by psychiatric or any other helping professionals. This is one of the reasons why most
migrants do not see psychiatrists or other professionals. One informant even went to the extent of denying the need for psychiatric treatment for depressive illness.

"What I want you to be aware of is that there is no absolute necessity for someone with depression to see a psychiatrist. Instead, it is better to look for basic solutions to the root problem. Without addressing the root cause, there is no use of sitting in a consultation room and talking, talking, and talking about issues that have marginal relevance to the root cause and to the problem. It is hard... The cause of depression is the individual himself, not because the person likes to have it but because he is overloaded and can not bear."

Mistrust and lack of confidence

There is a remarkable mistrust on psychiatric drug prescription and regimen on the part of migrants who were once in the psychiatric setting for treatment. Reportedly, prescribed psychiatric drugs are scarcely taken but rather are thrown away into waste bins. Patients then pretend to all concerned as having taken the drugs. This is because migrants have a seemingly baseless suspicion of the "ulterior motives" on the part of psychiatrists for the prescription of the medicine other than its supposedly positive medical effects. Clinical experimentation and intended use of drugs to worsen the situation of the migrant patient to a state of complete insanity are the two explanations given to justify the suspicion and mistrust migrants have on psychiatric medication and treatment. During FGD, the psychiatrists criticized the mistrust as unfounded and defended their point by saying that no patient is forced to comply with the regimen of psychiatric drugs unless the patient is "psychotic and presumably harmful to the society." Besides, any psychiatric patient has all the rights to take or not to take prescribed drugs; there is by no means a forcible attempt on patients.

Serious doubts over and lack of trust in the very capacity of the psychiatrists to bring any meaningful help for depression as an illness was also observed. Informants asserted that the psychiatric way of understanding the etiology of depression is very far from the way they deem to see depressive illness. As might be expected, the informants with perceived differences in understanding depressive illness do not find psychiatric treatment (e.g. drugs, talk and running therapy) appropriate and efficacious as far as their illness is concerned. Stressing the importance of therapeutically working on the root cause of depressive illness [this often could be outside the
sphere of the helping relationship], Selam gave the following revealing and deep statements to make the point that what Dutch psychiatrists here think causes depressive illness and their treatment approaches are not always applicable to all groups of people. On top of this, she sees the end of the psychiatric communication that takes place between parties who do not share similar theories of etiology as superficial guidance and the therapy as misplaced and lacking depth.

"...the causes of their[migrants'] depression are hardly understandable for Dutch psychiatrists. It seems to me that Ethiopians are not the type of people who believe in the therapeutic efficacy of talking... telling their problems to professionals. For instance, it is written in the Bible that if you advise a hungry person to sit by the side of a fireplace, that is not the solution to his problem. How can a person who does not possess a residence permit, who is in consequence insecure and depressed see therapy,... talking as a solution to his problems? A lonely person wishes to live with others and to get rid of depression. To him, the psychiatrist's advice the he has to socialize, have coffee with friends, that he does not have spend time alone is nothing. He does not want to be fooled with superficial guidance that boils down to nothing. Our mind can never be fooled. Conversation is not what he needs...[Nigirig aydelem yesu timatu!] Or it is not at all his interest to let his inside out and complain that he has no permission to live in Holland or... What he needs is security. He knows very well that counseling or other forms of psychotherapy are of no avail to him. What I believe the solution is to nip the root cause of the problem, not therapy... Therapy is not deep."

The above point was sensible when presented to the psychiatrists during the FGD and they agreed on the importance of sharing similar mental health behavior models for the success of any psychiatric contact. They also noted the recognition of limits and potentials of psychiatry when it comes to dealing with mental problems and admissibly some of the causes of mental disorders could be outside the psychiatric area to make an influence on. In short, the above reason given for not seeking help from clinics was well taken by the psychiatrists.

Fear of being used as experimental subjects for clinical trials

There is a widely held belief among migrants that patients who visit psychiatric hospitals could possibly be used as experimental subjects in clinical trials without their knowledge and consent. When informants were asked why migrants who suffer from depressive illness do not see psychiatrists, the reason they give other than the above mentioned ones, is that they do not want to be guinea pigs for the testing of psychiatric drugs. Many stories are told to support the alleged experimental use of patients without their knowledge. A story of a young man on whom, it was
narrated, various types of drugs “have been tried one after the other while his situation getting worse i.e. gaining weight (abnormal fattening) and turning delusional and eventually found dead.” There are also fragmented and hearsay stories of patients who committed suicide after discovering they were being used in experiments and patients who are “kept in hospitals for long time since their mental state got worse due to the administration of a variety of drugs on them.”

The reaction of psychiatrists when this topic was raised during the focus group discussion was awful amazement and wonder as to how wildly the situation was imagined by migrants. In response, the psychiatrists said that the Ethical Standards Committee examines any proposed medical research before it is undertaken and there are rigorous controls and demands on securing the informed consent of human subjects for any medical investigation. In sum, they made clear that no medical experiment is ever conducted without getting the participants’ informed voluntary consent. The Committee as an overseer also looks through the potential benefits and consequences of the experiment and has the right to reject the proposal if found possibly to have health hazards on the human subjects. In light of all these, it is very hard to empathize with migrants in their fear of being used as experimental subjects.

Suspecting hidden institutional communication

Informants are very inclined to think that there exists an invisible co-operation of the psychiatric staff with the Police. Informants seriously doubt the innocence, confidentiality and ethicalness of psychiatric caregivers and of the psychiatric health system in general. This is largely because the information migrants had given as asylum seekers to the Police may be and often is contradictory to or is a modified version of their real history and the Police are alleged to cross-check the psychiatric case history with what the Immigration Office knows about the migrant patient. Migrant patients then find themselves in a dilemma when there comes a strong need to see a psychiatrist [if at all they considered seeing a professional for their depressive illness]. Often times, it is reported migrants opt for not paying a visit to a psychiatric clinic as a solution to the dilemma.
For this, the psychiatrists in the FGD gave a brief response saying there is a lack of knowledge on migrants’ part as to how the service sectors work in Holland and how impenetrable the Dutch health care system is when it comes to revealing and giving access to patient information. They also added the fact that psychiatric clinics have the legal right to certify if a patient [referred by the Police] deserves treatment in Holland based on strong clinical evidence and whether the migrant is suffering from some kind of mental disorder. It is only for the certification purpose that the psychiatric clinics co-operate with the Police, not at the level of patients’ case history.

*Being suspected as malingerers [as trying to make a weighty case to the Police]*

As pointed out by the psychiatrists above, migrants who claim to suffer from some mental disorder are referred to psychiatric clinics to confirm if they are truly having a mental problem before some immigration policies are waivered and the migrant be allowed to get a permission to stay and/or live in Holland. Informants reported on migrants who happen to have encountered the suspicious attitude and questioning of psychiatrists to find out if the migrant has come to feign a depressive illness and get a medical certificate for it. This reportedly makes people who have at least once been in the hospital less motivated to see psychiatrists again. During the FGD, all the psychiatrists accepted this point as valid and briefed on the load and the problems they have to identify malingerers from those with real need for treatment.

*Problems of language/ Miscommunication*

Those few migrants who seek help from psychiatric clinics face a problem of language and being diagnosed as having no apparent psychiatric disorder. Thus, they prefer not to seek the services again if it is not going to help. As it is the responsibility of the service provider to ensure that communication is clear and comprehended, the clinics use interpreters, bilingual phone translators, child translators and sometimes advise the patient to bring a trusted translator along. And the language issue is not seen as a big problem by psychiatrists. What is a real challenge to the psychiatric clinics is the underdiagnosis of mental disorders, depressive illness included.
Among those who happen to reach the clinics, there is a tendency to produce a milder picture of their problems and to drop out if they are told that they are suffering from depression. The first tendency might be due to the need to get professional help without being labeled as depressive [paradoxical]. This is not only to avoid the stigma attached to it in the migrant community but also not to leave a black spot on their clinical record that is thought to be looked through for important government considerations and decisions. For instance, the clinical record is said to be consulted if one applies for a job to see how mentally fit the applicant is for the job. The second tendency is likely to be due to the disagreement/disappointment with the diagnostic results.
Chapter Four

IV. Concluding Remarks

This psychiatric anthropological study focused on the conceptualization i.e. the knowledge, opinions, illness experiences and health seeking behavior of Ethiopian migrants to depressive illness. With an emphasis on the subjective definition of actors, it was assumed in the study that the nature, course, and manifestations of depressive illness are far from being universal phenomena and are greatly shaped by individual, social, and cultural aspects. Needless to say it was also assumed that views and beliefs about depressive illness and the way depressive illness is experienced, interpreted and expressed are closely linked and these sociocultural artifacts significantly influence health behavior, diagnosis and treatment of depressive illness. These interlinks appear to take a different anthropological profile and cross-cultural significance when the target group of the study is a migrant community in a different cultural context. It was reported in some studies that migration by itself is not a risk factor to mental illness. But when it is accompanied by the low level of culture-sensitivity and appropriateness of mental health services in the host society, the level of social and cultural integration, language problems, lack of ethnocultural community to provide support, traumatic pre-migratory experiences, and separation from family that it becomes a precipitating condition. Taking into account the challenges faced by the Dutch mental health care system in the provision of psychiatric services to an exceedingly multicultural patient population and the reported prevalence of the problem of depression, this study on Ethiopian migrants living in Holland was designed and conducted to throw light on their conceptualization of depressive illness from an emic perspective.

This paper is an anthropological adumbration and description of the knowledge and experiences of twelve Ethiopian migrants with respect to depressive illness and the juxtaposed analysis of their conceptualization with the psychiatric perspective on depression. These participants have been outside their country for at least five years and could not strictly and culturally speaking be representative for Ethiopians as a cultural group, leave alone for the migrant community in Holland.
This is mainly because the migrant informants' belief system, outlook, general attitude, views, and explanatory forms have noticeably undergone changes and modifications as a result of acculturation and loss of contact with the culture of origin. Therefore, this ethnographic representation and the outcomes of the study should not be seen as comprehensive and conclusive.

One of the findings of the study is that informants hold gross and crude views on the essence and forms of mental illnesses. In the minds of the informants, the essence and general meaning of mental disorder was secondary to the labels they use to refer to instances of mental problems. There were many occasions when a particular mental illness such as anxiety or stress was given as an equivalent, not as a form, of mental disorder. This is frequently observed on the definitions of mental disorder given by informants. Besides, there is a tendency to characterize mental illnesses by their symptoms and consequences with less concern with their likely causes. As is demonstrated in the third chapter, the general criteria used as identifying characteristics of mental disorders i.e. self neglect, going naked, taking aloud and destructiveness are so broad and are not adequate for the recognition and detection of psychiatric cases. In addition, the conception that non-psychotic forms of mental illness like depression and anxiety disorders are not essentially pathological states that need to be treated is observed among informants. This view points to the higher level of psychological and physical threshold above which informants label experiences as pathological or non pathological and to the possibility of regarding some neurotic disorders as being 'normal' human responses and behaviors. What is noteworthy here is that spiritual causes for mental illnesses are rarely put forward by the migrant informants as opposed to the important role they are presumed to play in the causation of mental pathology in the culture of origin.

Coming down to the central focus of the research i.e. depressive illness, it was learnt that depression as a psychiatric disorder with its core symptoms is not known among informants. This does not mean that informants do experience or have no cognizance of depressive symptoms [as outlined by psychiatrists]. All of the depressive symptoms were described during interviews but they are rather organized under an entirely different experiential system. In line with the knowledge and experiences of informants and the cognitive system that backed up their classification of the depressive symptoms, four depression-related symptom complexes have been analytically
developed. These complexes are the chinket complex, the rasin mettal complex, medebet and dibirt. They lack neat demarcation and overlap on many instances. The chinket complex, a syndrome with no recognized mood disorder, is characterized by preoccupation with some thought and feeling of insecurity and a sense of limited control. It appears to share some symptoms with depression as a psychiatric disorder and it is not regarded as having similar course and manifestations. Most signs and symptoms of anxiety and stress disorders overlap with this category of symptoms. Likewise, dibirt is characterized typically by a transient and fleeting experience of low mood and lack of interest. From the study, this complex differs from chinket in that there is a possibility of losing hope in the subject of concern, increased severity and long duration. It comes close to ‘normal’ or non-clinical depression in essence. Unlike dibirt, physical symptoms—lethargy and headache—and apathy are the distinctive features of medebet. Unhappiness, hopelessness, carelessness, aimlessness and pessimism are the distinguishing symptoms of the rasin mettal complex. In short, at a very fundamental level, depressive symptoms are all reported to be present and experienced by migrants but the way they are socially and culturally organized, labeled, communicated and reacted to is found to be different.

None of these symptom complexes but the most severe form of chinket is regarded as mental disorder and the others are seen as ordinary, unavoidable parts of life and ‘normal’ patterns of behavior. The role of the individual in the causation [occurrence], management and handling of depressive illness is perceived as significant among informants. Thus, blame for depressive illness is directed to the individual and the social stigma attached to the illness in consequence makes the open admission of having depressive illness and seeking help is interpreted as a shameful behavior. The fact that individual qualities such as stamina, determination, and high bearing capacity are regarded as protective elements from depressive illness is an inappropriate attribution. The other interesting finding is the display of some symptoms of depressive illness to play a sick role and get exemption from social functions and responsibility. The place of Zar spirits in possessing the mind and depressing the individual is indicated; the attribution of depressive illness to Zar spirits for functional ends is pointed out as well. Over and above, depressive symptoms are sometimes regarded as aspects of the personality of the individual. The role of the Zar spirits and the functional
dimensions of depressive illness should be further explored to see how they are related to one another and how they influence the form and manifestation of the depressive illness.

With regard to the etiology of depressive illness, poverty and poverty-born stressful conditions, insecurity and uncertainty over the present and the future sustenance of ones life [existential crisis], repeated failures and frequent losses, and loneliness [seen as a cause not as a symptom] stand out as general perceived causes for depressive illness. Furthermore, loss of achieved social and economic status and a sense of having no control over the course of ones life, inability to be up to familial expectations, shame and guilt feelings resulting from wrong deeds, growing without parental love and a sense of responsibility and concern with national affairs are thought to precipitate depressive illness. The long and complicated process of getting residence permit to live in Holland is the most frequently reported stressful condition that is believed to lead to depressive illness. The development of a sense of insignificance, suspiciousness and negative thoughts as a result of the mistreatment by the Police and negative migratory experiences together with the ambiguous expectations and prejudiced attitudes of the local people at school and work place create a vulnerable situation for depressive illness. Neurobiological causes and genetic predisposition to depression are neither given nor accepted as possible explanations for depressive illness.

An attempt to handle depressive illness individually [i.e. self-care] is the most preferred health seeking strategy among Ethiopian migrants. This is because of the migrants’ orientation that depressive illness is an individual’s affair. It is only when the self-care attempts fail that migrant tend to seek help from close friends and folks. This help is often in the form of giving advice, sharing experiences and co-operating in bringing an end to the perceived causes of the depressive illness. Help seeking for depressive illness from psychiatric clinics is reportedly low primarily due to the migrants’ conception that depressive illness is not medically treatable. The lack of trust in the ability of psychiatrists to provide appropriate help, fear of being used as experimental subjects, suspecting hidden communication between the Police and the psychiatric staff, language problems and fear of being labeled as depressive are the salient reasons why migrants do not utilize psychiatric services.
There is a limited awareness and appreciation of the potentials and limits of psychiatry among migrants as far as the treatment of mental illnesses is concerned. Moreover, migrants tend to have a general misperception on the importance of psychiatric diagnosis and potential efficacy of psychiatric treatment. The findings related to health seeking behavior could give some insights to local psychiatrists who in one way or another come to work with this migrant community about their beliefs and understandings of depressive illness. Moreover, this short anthropological account of the conceptualization of depressive illness among Ethiopian migrants in Holland could serve as a starting point in researching into the social and cultural dimensions of depressive illness on relatively culturally homogeneous group living in Ethiopia or elsewhere.
References

1. The Utah Museum of Fine Arts.

2. Kazdin, E. Allan


4. The Columbia Encyclopedia (Fifth Edition)

5. Freud, Sigmund.

6. Fernando, Suman

7. Kleinman, A. and Byron Good

8. American Psychiatric Association
   1994 *Diagnostic and Statistical Manual of Mental Disorders (fourth edition).* Washington DC.

9. Castillo, R.J.

10. Mezzich, E Juane et.al

    1999  *Social and Environmental Processes.* At http://www.nimh.nih.govy/publicat/baschap.cfm

12. Murray, J. L. Christopher and Alan D. Lopez

13. WHO
14. The Economist

15. Holgan, John.

1986 Ethnicity, Social Status and Psychiatric Disorder in the Epidemiologic Catchment Area Survey. At http://www.utmb.edu/disorder/mood/epide/eh1.htm

17. Wichert, Robert


20. Tizon, Orlando.

21. Van Dijk, Rob

22. Richters, Annemieck.


24. Mann, J. John and David J. Kupfer (eds)

26. Seligman, M.
   1975 *Helplessness*. Freeman & Co. USA.

26. Abramson, L., Seligman, M., & Teasdale, J.

28. Cockerman, W. C.

29. Collins, P. H.

30. Tekle-Haimanot, R.

31. Alem, A and et.al.

   1997 *Butagira Mental Health Project. CIDI 2.1 (Composite International Diagnostic Interview), Section A, E, F, G, P and X. Butagira Study on Course and Outcome of Schizophrenia and Bipolar Disorder. Interviewer's Copy*.

33. Messing, Simon D.
Appendix A: Symptoms of Depression

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.

2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.

4. Insomnia or hypersomnia nearly every day

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

6. Fatigue or loss of energy nearly every day

7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Appendix B- Interview Schedule

This interview guide consists of a list of general themes and discussion topics used during data collection. This schedule was far from being exhaustive and was open to structural or content-related changes, additions and omissions. It was generally aimed at serving the objective of synthesizing an analytic description of informants’ understanding, experience and interpretation of depressive illness. The *why* and *how* inquires, though no stated here, run through all the discussion topics to help unravel the reasons that back up conceptualization of depressive illness, illness behavior and how the illness is experienced.

**Themes**

1. **Mental Illness**
   - Essence and definition
   - Meaning
   - Types of mental disorders
   - General symptoms and identification of mental disorders
   - Course
   - General perceived etiology

2. **Depressive Illness**
   - Definition, forms, meaning and equivalent/similar local terms
   - Thoughts, feelings and behaviors accompanying the illness
   - Presentation and communication of depressive illness
   - Perceived causes/Explanations
   - Premigratory and post-migratory conditions related with depressive illness
   - Depressive illness experience
   - Course and treatment of depressive illness
   - Help seeking behavior
   - Reason for not seeking psychiatric help for the problem of depression.