Depression

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Depression, which psychiatrists regard as a most common mental illness, has been examined by anthropologists especially closely since the 1980s. While most medical experts consider depression as a universal, neurobiological disease that requires a global public health intervention, anthropologists instead ask why the illness known in psychiatry as ‘depression’ appears to have been extremely rare in much of the world until very recently. They also investigate how a supposedly neurobiological disorder could possibly arise with increasing frequency in so many places in such a short time. Some anthropologists suggest that the apparent rise of depression is co-constituted by changes in diagnostic criteria, a medicalisation of normal distress, as well as the growing influence of the global pharmaceutical industry. They have questioned the assumption of a clear-cut border between normalcy and abnormalcy, illuminated depression’s social origins, and problematised the extension of medical power into spheres of life that used to lie beyond the reach of medicine. This entry shows how anthropologists investigated depression before and after its alleged global rise in the 1990s, and how this phenomenon can be understood as a cultural, historical product profoundly influenced by socioeconomic transformations of the current time.

Introduction

Depression, which psychiatrists define as a constellation of low energy, low self-worth, and low mood, has emerged as a global concern since the 1990s. Calculated in terms of disease burden through disability-adjusted life years (or DALYs), depression is deemed the world’s second most common disorder after cardiovascular disease (Murray *et al*. 2013). It reportedly affects more than 264 million people worldwide (Ritchie & Roser 2021). Most medical experts and epidemiologists consider depression to be a universal, neurobiological disease that requires a global public health intervention. Anthropologists, on the other hand, ask why the illness known in psychiatry as ‘depression’ appears to have been extremely rare in much of the world until very recently, and how a supposedly neurobiological disorder could possibly arise with increasing frequency in so many places in such a short time. Some anthropologists suggest that the apparent rise of depression is co-constituted by changes in diagnostic criteria, a medicalisation of normal distress, as well as the growing influence of the global pharmaceutical industry. Anthropologists tend to be critical of biologising perspectives that see moods and emotions as the same across the world, irrespective of cultural and social contexts (Ecks 2016).

This entry will survey some anthropological works on the subject before and after the alleged global rise of depression in the 1990s. The ascent of depression mirrors that of suicide, which was a global concern at

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the turn of the twentieth century, leading to its sustained epidemiological study and a theory of individual mental distress as a symptom of collective malady (Durkheim 1952 [1897]). The rise of depression at the turn of the twenty-first century has provided a fertile ground for new anthropological concepts and ethnographic approaches. This entry will show how anthropologists have frequently questioned the assumption of a clear-cut border between normalcy and abnormalcy, illuminated depression's social origins, and problematised the extension of medical power into spheres of life that used to lie beyond the reach of medicine. Anthropologists tend to challenge biomedicine's one-size-fits-all prescriptions for treatment and its underlying assumption that a person with symptoms of depression can be treated as an individualised and decontextualised being, cut off from social interactions and complex power relations (Kleinman & Good 1985). The entry also examines the historical implications of the current rise of depression by considering its relationship to wider socioeconomic transformations, including the neoliberalisation of selfhood.

Culture, gender, and situated biologies

If few psychiatrists dispute the universality of depression today, it was still a matter of debate in the mid-twentieth century, when the level of depression reported from most non-Western societies was low. Some psychiatrists even wondered if depression was a culture-bound Western illness, which they saw as reflecting a supposedly more mature and introspective Western self (see Littlewood & Dein 2000). This model of depression derives in part from the Western concept of melancholy that preceded it and that is rooted in Greco-Roman humoral medicine. Melancholy was not just a pathology, but was also seen as a source of reflexivity and creativity (Jackson 1986, Radden 2000). This line of thinking led some psychiatrists to assume that the relative lack of depression among non-Westerners was a sign of their immaturity and lack of insight, even a lack of Christian guilt, which made them immune to depression (see Littlewood & Dein 2000). One of them even echoed Jean-Jacques Rousseau's theme of 'noble savages' in claiming in a WHO report that Africans were not prone to depression because of their 'lack of responsibility' (Carrothers 1953, cited in Beiser 1985: 273).

Residue from these racialised and ethnocentric ideas continued to be found in later twentieth century psychological and psychiatric discussions that depicted Westerners as introspective and intellectually articulate 'psychologisers' and non-Westerners as unreflexive and more instinctual 'somatizers' (see White 1982). They explained the relative absence of depression among non-Westerners in terms of their alleged incapability in recognising psychological distress, which would instead be expressed as bodily symptoms (for criticism, see White 1982 and Kirmayer 1999; Ecks 2013, Kleinman & Good 1985). Women and the working class tended to be depicted as 'somatizers' well into the late-twentieth century (see Kirmayer 1999), speaking to the continuing presence of gender, class, and ethnicity biases in the psychiatric discourse about depression.

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Anthropologists made a case against conventional psychiatry by arguing for the 'work of culture' (Obeyesekere 1985). They showed that local habits and traditions, such as Buddhism, can protect people from depression by transforming negative affect into publicly acceptable narratives and symbols. In an influential yet controversial article, Gananath Obeyesekere (1985) discussed the case of a Sri Lankan man whom psychiatrists would diagnose with depression but who, in a Buddhist context, was revered for achieving enlightenment because he saw the world as full of suffering. No society distinguishes categorically between mental illness and health (Keyes 1985). Sorrow and grief are often linked with inner depth and dignity, not pathology (also see Good, Good & Moradi 1985). Given these alternative perspectives of experiencing the world, some anthropologists argued that the high rate of depression in the US was a product of an American ethnopsychology that prioritises the constant pursuit of happiness as a basic aim of human existence (Lutz 1985).

One important instance of historical and regional variations of depression is its gender ratio. Although depression today is said to affect women twice as much as men, even in the West at the turn of the twentieth century, elite men used to be depicted as more prone to depression (as an illness of reflexivity) than women. For women, a diagnosis of hysteria was more likely (Showalter 1985; Raden 2000; see also Metzl 2003). Cultural perceptions of women in distress, and the ways in which people perceive and engage with these women, are associated with regional prevalence of depression, along with symptom-reporting and help-seeking behaviours. For example, postpartum depression is a major public health issue in the US and Europe, but it is not universally discussed or even recognised elsewhere. Anthropologists have found that a social and ritual structuring of the postpartum period protects women from depression. This structuring includes '1) protective measures and rituals reflecting the presumed vulnerability of the new mother; 2) social seclusion; 3) mandated rest; 4) assistance in tasks from relatives and mid-wives; and 5) social recognition through rituals, gifts, etc. of the new social status of the mother' (Stern & Kruckman 1983: 1039). The authors also suggested that regional differences in prevalence might stem from the fact that most cases of postpartum depression are mild, not psychotic, and that such milder forms of depression are more easily shaped by cultural influences (Stern & Kruckman 1983).

In a study that introduced the influential concept of 'local biologies' (later redefined as 'situated biologies'), Margaret Lock (1993) argued that experiences of disease and illness need to be understood as products of interplay between individual biology and sociocultural environment. Lock noted a statistical anomaly in the WHO's cross-national depression survey, which reported that Japan not only showed lower rates of depression than its Western counterparts but that it was the only country included in the survey where slightly more men than women appeared to suffer from depression (Sartorius & WHO 1983). She explored this epidemiological puzzle by researching women at menopausal age in Japan and North America, and argued that an individual's genetics, lifestyle (including diet), social environment, and culture interact to create vastly different experiences of aging. Combining epidemiological and ethnographic methodologies,

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Lock also showed that the lower rate of depression among menopausal Japanese women was because they did not recognise 'depression' as such, and regarded menopause as part of a *natural* aging process. Importantly, the women in Lock's study, even those in trying socioeconomic circumstances, kept telling her that their suffering was insignificant, that they were even 'fortunate', when compared to their own mothers, who had survived WWII and its aftermath. This cultural, collective rendering of their suffering seemed to protect women from medicalisation, which would have turned natural processes of living and aging into matters for biomedical intervention.

The studies mentioned so far show that individual biologies are heterogeneous as they are formed out of particular local contexts, which also intersect with local politics of recognition and legitimisation of people's distress. Examining how certain symptoms and certain types of suffering elicit more sympathy and concern from others, anthropologists help to explain differences in prevalence rates of depression as well as in health-seeking behaviours and care provision. In Lock's study, for example, local politics that had an important, protective aspect for many women in distress also meant that the suffering of some other women, who did experience severe symptoms of menopause or depression, was often rendered invisible and left untreated, increasing their physiological and psychological pain. Given that cultural discourse can be a double-edged sword, anthropologists pay close attention to the fact that local forces do not have the same effects on all people. At the same time, reducing depression to these women's physiological differences and/or neurochemical imbalances would be to omit, among other things, the socioeconomic environment and local gender politics that structure their distress in the first place[iii]

Distress, misunderstandings, and the politics of psychiatry

Recognising that people in much of the world experience and express their distress by means other than the psychiatric concept of depression, anthropologists from the 1980s began employing the notion of 'idioms of distress' as culturally diverse ways of expressing psychosocial distress (Nichter 1981). This concept has proven highly productive for clinicians as well, as the term 'idiom' does not presuppose pathology and can be used to capture a wide range of local experiences, symptomatology, and help-seeking behaviours that might previously have gone unnoticed (see Lewis-Fernando & Kirmayer 2019). Mapping out regional idioms, anthropologists found depression-like experiences expressed in a wide range of descriptions of nervous conditions such as 'nervos' in South America, 'nerve exhaustion' in East Asia, as well as other psychophysiological idioms like 'heart distress' in the Middle East. They noted how common these depression-like symptoms were across cultures when they included somatic expressions of psychosocial distress, leading them to question the definition—based in Western psychiatry's mind-body dualism—that defines depression predominantly as a disease of the mind (also see Marsella 1982, Kleinman 1988, Ecks 2021).

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National politics and state medical systems also help shape distinctive forms of medicalisation. In a pioneering work on this topic, Arthur Kleinman's ethnography of China (1986) showed how a particular Chinese usage of 'neurasthenia' (a psychiatric term for depression-like symptoms common at the turn of the twentieth century) emerged in the 1980s as part of a powerful, state-sanctioned discourse, unthreatening to the political status quo. Showing how people used this idiom to channel their anger against injustice suffered during and after the Cultural Revolution, Kleinman proposed an analysis of medicalisation that moved beyond the idea of a top-down process of labelling and social control by medical professionals. Instead, he demonstrated how medicalisation can be a bottom-up process, where people's desire for social recognition of their suffering is intrinsically linked with state/biomedical legitimisation, which together produce an ambivalent form of liberation and empowerment for those in distress (cf. Yang 2018 on the official, individualising usage of 'depression' in China today).

Local notions of depression do not merely remain at the level of popular or folk knowledge but in fact shape and are shaped by professional psychiatry, which shows remarkable regional variation. This became apparent when a US-UK comparative study (Kendell *et al*. 1971) showed that, given the same set of symptoms, American psychiatrists were far more likely to diagnose schizophrenia while their British counterparts were more likely to diagnose manic-depression. Such differences in localised theories and practices are also expressed in the varying 'prototypes' of depression, or psychiatric ideas about what or who constitutes a 'typical' case (Young 1995). The typical subject of depression in Japanese psychiatric literature, which developed in close dialogue with the German psychiatric concept of *typus melancholicus*, has long been regarded as a burned-out white-collar worker, in sharp contrast to the North American psychoanalytic prototype of depression as an illness of melancholic housewives (Kitanaka 2012). Even at the level of hard scientific terms, depression is a malleable, multifaceted idea, and psychiatric language remains inextricable from the reality that it co-creates the illnesses it attempts to represent (Foucault 1973 [1961], Hacking 1999).

The heterogeneous nature of depression at the local level often goes unaddressed in biomedicine, in part due to the division between medical science and psychiatric practice (Young 1995, Luhrmann 2000). As Allan Young (1995) has shown, medical science, at its core, depends on a paradigmatic 'style of reasoning' (Hacking 1982) with a remarkably stable body of knowledge and ideologies about objectivity and universality; clinical medicine, on the other hand, remains protean and multiplicitous, working in tandem with local knowledge and discourse. A scientific style of reasoning provides practitioners with a sense of stability, order, and coherence via an understanding that not all scientific facts have equal 'truth' values (Gilbert & Mulkay 1984, Young 1995). Scientific psychiatry (i.e. research-based, academic psychiatry) emanates from only a handful of European and North American power centres and spreads to the 'periphery', while clinical psychiatry frequently remains a 'local knowledge', rarely traveling to the knowledge-production centres of scientific psychiatry (Cohen 1995). Communication is mostly

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unidirectional, and when medical science further distances the data from the world of local clinical practice, patients' individual stories are replaced by fragments of voiceless material bodies in the laboratory. At this stage, the lack of dialogue between scientific psychiatry and local practice becomes more gravely problematic (Young 1995).

Given the power asymmetries in scientific psychiatry, 'discovering' depression in the non-West and imposing a decontextualised and universalised Western concept of depression on these societies may amount to a 'category fallacy'. That is, it may give seemingly universal legitimacy to a culturally constructed concept and its use among those engaged in cross-cultural research (Kleinman 1977, Lutz 1985). Kleinman (1988) cites Obeyesekere (1985) in discussing the culture-bound syndrome among Southeast Asian men called *dhat*, a feared 'semen loss' that results in draining energy and weakness (Ecks 2013). Kleinman and Obeyesekere show how absurd it would seem to Westerners for psychiatry to adopt the concept, standardise it, train psychiatrists globally to correctly diagnose it, educate the public about it, and work with pharmaceutical companies to invent and market a drug for it. To most observers, this would create unnecessary anxiety and a desire for therapeutic treatment for an illness that does not exist as such. Yet when it comes to Western psychiatric concepts such as depression, a similar process is normalised and might even be praised as a form of medical humanitarianism. This is because depression is regarded by the Western psychiatric establishment as a 'real' phenomenon, but semen loss is not. Psychiatry has also been criticised for depending on databases mostly developed with and for the 'mainstream population in Western societies' (i.e. 'middle class whites') and naively applying it to all other people (Kleinman 1988: xii). Given such subtle but important power disparities, the anthropologist's job is to attend to differences and ask how local knowledge is produced and what remains 'local', how local and global psychiatry might communicate with one another, and how local psychiatric concepts might influence the production of global and scientific psychiatric knowledge (Cohen 1995; also see Pentecost *et al*. forthcoming).

Globalised depression

Sensitivity to local differences has become more important than ever with the global rise of depression since the 1990s. Previously understood as a culture-bound syndrome of the West, depression has become regarded by many as a universal disease of epidemic proportions. This change was brought about partly by the broadening of the concept of depression in the *DSM-III* (*The Diagnostic and Statistical Manual of Mental Disorders, Third Edition*, published in 1980), the development and marketing of a new generation of antidepressants, and the movement for global mental health. As anthropologists working in places where depression used to be rare witnessed its sudden rise, they began documenting the 'making of depression' on the ground, or the process by which a constellation of low energy, low self-worth, and low mood comes to be regarded as a clinical symptom and then a disease. In analysing these processes, they have often used Ian Hacking's (1995) notion of a 'looping effect' in which people's experience living with the label of

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depression alters how they experience the condition itself. As the label is more frequently applied, people appear to change in ways that affect both how depression is classified and how people describe and live with it (Hacking 1999). Such changes prompt us to wonder if psychiatric globalisation serves to erase regional theories and homogenises understandings of depression.

Initially, many social scientists, psychiatrists, and philosophers were particularly concerned about the global spread of antidepressants even to areas where depression had not been widely recognised. They noted that pharmaceutical companies carefully tailored their marketing strategies to cultural contexts by employing the most effective local idioms of distress in promoting antidepressants. Thus, they spoke of 'mind food' in India and of 'a cold of the soul' in Japan (Ecks 2013; Kirmayer 2004, Applbaum 2006). Critics worried that the aggressive marketing of pills like Prozac might serve to replace pre-existing local understandings with biomedicalised approaches to depression. This, they thought, might instil a concept of a neurochemical self (Rose 2007), making people think that 'we are our brains', possibly impoverishing our understanding of human nature (see Vidal & Ortega 2017; also see anthropological critiques of neurobiology and how to integrate it with an ecological perspective in Raikhel 2015). Such biological reductionism, occurring in the era of neoliberalism, might further create 'happy' productive workers, who voluntarily soothed their dissent with pills in exchange for the illusion of control.

However, anthropologists have since discovered that both lay people and diagnosed patients are usually not fully persuaded by such biological reductionism (Vidal & Ortega 2017, Elliott 2003). Therapeutic effects of drugs do not just rely on neurochemical change but also on cultural attitudes (Rose 2007: 100; Ecks forthcoming). While American discourse initially suggested that people could recover their 'true selves' through the use of antidepressant medications (Kramer 1993), in Argentina, antidepressants were offered as treatment for symptoms which were understood to be political and economic ills (Lakoff 2005). In India, psychiatrists linked antidepressants with widespread cultural notions around nutrition, digestion, and somatic balance, encouraging patients to see them as *moner khabar* ('mind food'; Ecks 2013). In Pelotas, Brazil, economically-poorer youth tended to use antidepressants for longer periods and in a long-standing interpretive frame that encouraged them to subtly internalise the assumption that their psyches are inherently weak and immature. In contrast, middle-class youth used antidepressants to temporarily facilitate the crucial work of refashioning a resilient internal self. These different uses served to reinforce long-standing views of the psychological inferiority of marginalised populations (Béhague 2015). These wide-ranging discourses surrounding antidepressant use demonstrate that, despite its globalisation, depression continues to be a localised 'polysemic symbol' (Barrett 1988: 375) in which 'various meanings and values are condensed into a syndrome' (Lock & Nguyen 2010: 73).

Even in the US, where antidepressants like Prozac were initially hailed as magic happiness pills during the 1990s, scepticism grew about whether it was wise to even try to achieve such constant happiness. Leading psychiatrists began to debate whether the pharmaceuticalisation of everyday distress might render people

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less tolerant of negative emotions such as sorrow and grief, leading to what Allen Frances, the chairman of *DSM-IV*, called the 'loss of sadness' (Frances 2013). Many critics are concerned about how the loss of what was previously considered 'normal' sadness could weaken the traditional resources people have used to confront hardship or loss (for example Elliott & Chambers 2004). This debate was heightened when a crucial clause in the *DSM-5*, which used to make an exception for bereavement in the diagnosis of depressive disorder, was altered. Since 2013, even people dealing with a loved one's death can receive a diagnosis of depression (Ecks forthcoming). As Kleinman and others have argued, no reliable scientific evidence exists that can determine how long a 'normal' bereavement period should be (Kleinman 2012). These psychiatrists warn that when even grief is made an object of pharmaceutical intervention, resulting social pressure means pharmaceutical treatment of depression is normalised.

The recognition of the limitation of pharmaceutical cures has led to the flourishing of other psychosocial interventions and local reflections about the nature of depression. In post-dictatorship Chile, both antidepressants and group psychotherapies are offered to the poor as part of the National Depression Treatment Program, aimed to combat the world's second highest prevalence of depression. Clara Han (2012) shows, however, that women living in poverty see such neuropsychological intervention as little more than a temporary respite with little efficacy for solving their everyday struggles. As these women bear the burden of redeeming themselves both from the nation's traumatic past and the economic precarity brought on by radical monetary policies, they discuss depression as embodying the interconnectedness of domestic troubles, debts, and social insecurity, problems for which neuropsychology has little to offer (Han 2012). Similarly, in Iran, depression has served as an idiom for working through generational traumas, where the past memories of the revolution and international conflicts are woven together to express today's collective and personal predicaments (Behrouzan 2016). The rise of psychotherapy in Mexico (Duncan 2018) and China (Zhang 2020) since the 2000s has helped cultivate people's desire for an 'entrepreneurial self', even as it seems to also generate a space for reflecting on the psychological toll that this new self may bring. These regional discourses about depression suggest that medicalisation can provide a 'structural possibility' (Corin 1998) for people to detach from and reflect on pathogenic cultural expectations and to effect important social transformations.

Signs of profound structural changes can be found in areas where depression has been widely debated as an illness of labour and a problem of productivity at the national level (on economy and depression, see the classic sociological work by Brown & Harris (1978). The increasing number of distressed workers in Finland sparked a public concern as it was seen as a sign of the decline of the welfare state (Funahashi 2021). A diagnosis of depression has become a weapon of the weak for signalling their socioeconomic precarity and social pathology in Italy, where the debate about workplace bullying and workers' psychopathology, including depression, arose. As people place the blame on neoliberalism, which they see as destroying their culture of safeguarded work, 'mobbing experts' are engaged to diagnose and intervene

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into the high stress level of the workplace, paving a way for a solution at an organisational, structural level (Mole 2010). The national debate regarding 'overwork depression' and 'overwork suicide' in Japan has turned these diagnoses into powerful tools workers and families can use to highlight the dire cost of work stress and emotional labour on their health. After medico-legal debates about the exact cause of depression—whether it is a problem of workers' neuropsychological vulnerability or a pathogenic environment—the government has changed labour policies to remedy the psychologically toxic work environment. At the same time, work is seen as both a cause and a cure for depression, as new forms of surveillance technologies and occupational therapies have emerged as ways for managing and recovering the depressed (Kitanaka 2012; also see Bowen forthcoming on the near-absence of depression among 'occupational mental disorders' in Chile).

Global therapeutics: quantified selves, resilience, and anonymous care

The advent of digital psychiatry is shaping a global platform for the prevention of depression. This also raises concerns about novel forms of biomedical surveillance. While recording one's moods has long been part of a psychiatric treatment for depression (Martin 2007), the accessibility of digital technologies today is encouraging more and more people to keep track of their biorhythms, cognitive patterns, behavioural habits, and moods (Ecks forthcoming). Digitalised neuropsychological management and interventions now include computer software that can quantify stress via heart rate through interaction with input devices. These prevention and early intervention technologies expand the number of people who begin to identify with the idea of the 'quantified self', which refers to both self-tracking technology and the community of users of such tools (Lupton 2016). While these tools can be empowering for those who want to be in control of their own health, such technologies might have the effect of taking depressed people out of the emotional realm and the particular social contexts where they feel their symptoms, and relocate them to the public, quantifiable realm of human engineering and rational management (Kitanaka 2015). Compared to previous forms of therapeutics technologies that often incorporate historical reflections on the nature of one's predicament, these digitalised systems of state/corporate/market 'care of the self' (Foucault 1990, Foucault *et al*. 1988) are far from engaging with social origins of depression and largely remain at the level of merely encouraging individual transformation (cf. Borovoy & Zhang 2017). The spread of such therapeutic/surveillance technologies prompts us to ask whether they will end up reshaping social understandings of depression within the discursive limits of biopsychiatry, with its tendency to depoliticise illnesses and promote ideologies of individual responsibility and commodified health (cf. Comaroff 1982, Gordon 1988; also see Lovell & Susser 2014.).

Enhancement technologies for the depressed are another facet of emerging global therapeutics. To keep patients from developing depression and to help them recover from it, medical professionals based in the world's power centres increasingly emphasise resilience, a seemingly benign concept, as well as 'resilience

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training', with the stated aim of rendering people better able to handle stress. Particularly in the US, the military promotes positive psychology through resilience training and encourages soldiers to adopt a positive attitude as a tool for becoming more psychologically 'fit' (MacLeish 2013). Resilience glamorises the individual's transcendental power, which creates a potent lure for adopters. At the same time, it renders people's ability to independently recover from distress and live healthy lives into a therapeutically managed process. Young points out that handling everyday stress is being redefined as 'something to be achieved with the help of experts', so much so that resilience might, before long, 'displace effortless "normality" as the default condition of human life' (2012, 2014). Emily Martin (2007) shows how even mania, the opposite pole of depression, is now fetishised and commodified in corporate America as a source of creativity and high productivity. As some companies offer training to boost both one's manic power while maintaining healthy mood cycles, mood disorders like depression may become an entry point to one's subjectivity for experts promoting the further corporatisation of psychological health (also see Chua (2011) on resilience training for suicidal youths in Kerala).

As suicide is said to kill one person every 40 seconds,[21] treating depression as a way of preventing suicide has also become an urgent global issue. Globalising suicide prevention programs often take a universal form, despite the fact that their efficacy at the local level is often left unexamined. Problematising this and illuminating the high rates of suicide in the Canadian Arctic, Lisa Stevenson (2014) investigates the persistently high rate of suicide among Inuit youths, in particular, despite all the care that is given to them. Going beyond psychiatric conceptualisations of suicide and tracing Canada's history of 'welfare colonialism', she identifies one problematic factor in care services driven by mechanical, bureaucratic rationality—what Stevenson refers to as 'anonymous care'—whereby 'it doesn't matter *who* you are, just that you stay alive' (Stevenson 2014: 7, emphasis in original). Questioning this form of humanitarianism, she criticises the global suicide prevention programs that seek to define at-risk populations and provide a set of protocols that would enable volunteer carers to deal with suicidal individuals at a distance, without needing to invest themselves in the specificity of those individuals' suffering. The distance and anonymity afforded through this approach provides a certain freedom for both parties, but it also renders the suffering individual into a depersonalised 'case'. Stevenson discusses how these Inuit youths, a group all too often regarded as a 'problem' to begin with and who are ultimately not well served by the humanitarian care provided to them, come to see in suicide a 'leap into another way of being in time' (Stevenson 2014: 147)—and asks how they can begin to reconstruct themselves in an alternative regime of life, one that recognises other ways of living and dying (also see O'Nell 1996; Davis 2012, Garcia 2010, Meyers 2013).

Depression and neoliberal selfhood

In asking what might be the universal implications of the global spread of depression, let us take a step back and ponder the broader historical meaning of the rise of the neuropsychological management of the

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self. Sociologist Alain Ehrenberg (2010) argues that depression is the typical disorder of the current era. Ehrenberg's analysis focuses on understandings of mental illnesses from the 1900s to the 2000s. Social relations have changed from more hierarchical to more egalitarian, with a more equal distribution of wealth and status. In the 1900s, the prototypical mental conflicts came from struggles with authority and from deviance from clearly defined social norms. Conflicts lay *between* people. Since the second half of the twentieth century, flattening social hierarchies enhanced inner conflicts about motivation and decisiveness. Since then, conflicts lie *within* people's own selves. Ehrenberg describes how, today, all decision-making has to be done by oneself, within oneself. In other words, the rise of depression has to do with this fatigued self at a time one has to make so many decisions (Ehrenberg 2010: 223).

Building on Ehrenberg's argument, Stefan Ecks (forthcoming) analyses the new regime of 'neoliberal self' that serves to extend market competition within the self. According to Ecks, neoliberalism accelerates the dual process of fewer social distinctions coupled with an intensified drive at self-enhancement and becoming an entrepreneur. In earlier forms of capitalism, the goal of all this striving was the accumulation of capital through ascetic self-denial (Weber 2010 [1904/05]). In neoliberalism, the goal is not self-denial but self-satisfaction, even its maximisation. *Homo economicus* replaces outside partners of exchange with his own inner self (Foucault 2008: 226; Rose 1990; Brijnath & Antoniades 2016; Hardt & Negri 2017; Martin 2007). As the self takes itself as its own competitor in a market for getting the best deal from every moment of life (Scharff 2016), this creates a pathogenic condition where one feels that one can never do enough, never improve enough. Slow or stalled decision-making becomes a dreaded symptom; inability to act becomes a pathology of the current era (Leykin & DeRubeis 2010), which may have contributed to the global rise of depression.

The global desire for therapeutics from depression is thus a search for a new form of psychological governance. Ecks (forthcoming) argues how depression's main symptoms—of devaluing oneself, devaluing one's life possibilities, and having no motivation or energy to enhance life—all go together in this new regime of self. He points out that, just as much as sadness, depression is associated with being numb and without emotional sensitivity. As emotions guide decisions, they literally move the person 'out' from where they are. The numbing of emotions makes deciding harder, not easier. To live is to value, and to value means to feel, with the whole body, that one thing is better than another thing (Ecks forthcoming). The numbness of emotion is also another symptom, where affective indifference can lead to indecisiveness (Ratcliff 2015). Thus a recovery from depression involves recovering emotions, and all forms of therapy involve giving people the belief that they can heal and that alternatives to the current impasse exist (Csordas 2002; Hinton & Kirmayer 2017). As the feeling of hopelessness is related to not being able to imagine a better future, or to believe that improvement could be possible, recovering from depression means regaining the ability to see different possibilities for action as possible. How such therapeutics can be made available is a question that needs further investigation.

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Conclusion

The global medicalisation of the concept of depression points to the 'maximum universality' of depression, whereby it has become an object of biopsychological, scientific investigation. At the same time, it highlights depression's extreme heterogeneity (Ehrenberg 2010: 74). As a result of the plasticity of the notion of depression, it has been subjected to widely varying local interpretations and responses. Psychiatry has largely aligned itself with the universalist stance, emphasising genetic and neurobiological research and promoting methodological individual reductionism. Anthropology, in contrast, illuminates the vast variation of depression experiences across time and space, thereby providing a key counterpoint to reductionistic psychiatric views on causality and personhood (Kleiman 1988, Kirmayer 1999). The fact that biomedicine as a whole has shifted away from simplistic models of genetic determinism (Lock & Pálsson 2016, Rose 2018) suggests possibilities for collaborative engagement between psychiatry and anthropology that may encompass both biological and sociocultural views of depression (Kirmayer *et al*. 2015).

Anthropologists, with their historically strong interest in local life worlds and native points of view, have shed light on dimensions of depression that may not be easily accessible through a psychiatric lens. Such perspectives are becoming more important than ever given the politics of medicalisation today, as a multiplicity of social actors and institutions including psychiatrists, lawmakers, governments, pharmaceutical companies, and NGOs all exert their own ideas as to the nature of depression and how best to respond to it. This heterogeneity of views on depression—and indeed on human nature—provide the backdrop to anthropological research on the subject that is at once multifaceted and nuanced. As depression allows no easy answers to questions about its causality or effective cures but seems to touch more and more people as part of the spread of capitalism, it will continue to be an important focus for further investigation and ethnographic engagement.

Note

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[1] See Neitzke 2016 for a critique of the harm of biological reductionism in research on women and depression.

[2] Suicide: one person dies every 40 seconds. World Health Organization. News release. 9 September 2019 (available on-line: https://www.who.int/news/item/09-09-2019-suicide-one-person-dies-every-40-seconds).

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