are constrained by history and culture as much as by biology. Indeed, in the concepts of anthropology, biology, history, and culture are deeply interwoven.

In the chapters that follow I will apply this framework of cultural criticism to psychiatric research and practice. The attempt to apply psychiatric categories, so profoundly influenced by Western cultural premises, to non-Western societies is dramatically illustrated in cross-cultural research, the subject of the first three chapters.

Chapter 1

What Is a Psychiatric Diagnosis?

Disease is not a fact, but a relationship and the relationship is the product of classificatory process. . . .

Bryan S. Turner,
The Body and Society

What other taxonomies might revolutionize our view—for taxonomies are theories of order?

Stephen Jay Gould,
Animals and us

Individuals are types of themselves and enslavement to conventional names and their associations is only too apt to blind the student to the facts before him. The purely symptomatic forms of our classifications are based on the expressive appearances that insanity assumes according to the temper and pattern of the subject whom it affects. In short, individual subjects operate like so many lenses, each of which refracts in a different angular direction one and the same ray of light.

William James, cited in Eugene Taylor:
William James on Exceptional Mental States,
The 1896 Lowell Lectures

I am sitting in a small interview room at the Hunan Medical College in south central China. It is August 1980 and the temperature is over 100 degrees. I am sweating profusely and so is the patient I am interviewing, a thin, pallid, 28-year-old teacher at a local primary school in Changsha whose name is Lin Xiling.[1] Mrs. Lin, who has suffered from chronic headaches for the past six years, is telling me about her other symptoms: dizziness, tiredness, easy fatigue, weakness, and a ringing sound in her ears. She has been under the treatment of doctors in the internal medicine clinic

of the Second Affiliated Hospital of the Hunan Medical College for more than half a year with increasing symptoms. They have referred her to the psychiatric clinic, though against her objections, with the diagnosis of neurasthenia.[2] Gently, sensing a deep disquiet behind the tight lips and mask-like squint, I ask Mrs. Lin if she feels depressed. "Yes, I am unhappy," she replies. "My life has been difficult," she quickly adds as a justification. At this point Mrs. Lin looks away. Her thin lips tremble. The brave mask dissolves into tears. For several minutes she continues sobbing; the deep inhalations reverberate as a low wail.

After regaining her composure (literally reforming her "face"), Mrs. Lin explains that she is the daughter of intellectuals who died during the Cultural Revolution while being abused by the Red Guards.[3] She and her four brothers and sisters were dispersed to different rural areas. Mrs. Lin, then a teenager, was treated harshly by both the cadres and peasants in the impoverished commune in the far north to which she was sent. She could not adapt to the very cold weather and the inadequate diet. After a year she felt that she was starving, and indeed had decreased in weight from 110 to 90 pounds. She felt terribly lonely; in five miserable years her only friend was a fellow middle school student with a similar background from her native city, who shared her complaints. Finally, in the mid-seventies she returned to Changsha. She then learned that one of her sisters had committed suicide while being "struggled" by the Red Guards, and a brother had become paralyzed in a tractor accident. Three times Mrs. Lin took the highly competitive entrance examinations for university education, and each time, to her great shame, she failed to achieve a mark high enough to gain admission.[4] Two years before our interview, she married an electrician in her work unit. The marriage was arranged by the unit leaders. Mrs. Lin did not know her husband well before their marriage, and afterward she discovered that both he and his mother had difficult, demanding, irascible personalities. Their marriage has been characterized by frequent arguments which end at times with her husband beating her, and her mother-in-law, with whom they live, attacking her for being an ungrateful daughter-in-law and incompetent wife. Both husband and mother-in-law hold her responsible for the stillbirth of a nearly full-term male fetus one year before.

Over the past two years, Mrs. Lin's physical symptoms have worsened and she has frequently sought help from physicians of both biomedicine and traditional Chinese medicine. When questioned by me, she admits to more symptoms—difficulty with sleep, appetite, and energy, as well as joylessness, anxiety, and feelings that it would be better to be dead. She has an intense feeling of guilt about the stillbirth and also about not being able to be practically helpful to her paraplegic brother. During the past six months she has developed feelings of hopelessness and helplessness, as well as self-abnegating thoughts. Mrs. Lin regards her life as a failure. She has fleeting feelings that it would be better for all if she took her life, but

she has put these suicidal ideas to the side and has made no plans to kill herself.

From Mrs. Lin's perspective, her chief problem is her "neurasthenia." She remarks that if only she could be cured of this "physical" problem and the constant headache, dizziness, and fatigue it creates, she would feel more hopeful and would be better able to adapt to her family situation.

For a North American psychiatrist, Mrs. Lin meets the official diagnostic criteria for a major depressive disorder. The Chinese psychiatrists who interviewed her with me did not agree with this diagnosis. They did not deny that she was depressed, but they regarded the depression as a manifestation of neurasthenia, and Mrs. Lin shared this viewpoint. Neurasthenia—a syndrome of exhaustion, weakness, and diffuse bodily complaints believed to be caused by inadequate physical energy in the central nervous system—is an official diagnosis in China; but it is not a diagnosis in the American Psychiatric Association's latest nosology.

For the anthropologist, the problem seems more that of demoralization as a serious life distress due to obvious social sources than depression as a psychiatric disease. From the anthropological vantage point, demoralization might also be conceived as part of the illness experience associated with the disease, neurasthenia or depression. Here *illness* refers to the patient's perception, experience, expression, and pattern of coping with symptoms, while *disease* refers to the way practitioners recast illness in terms of their theoretical models of pathology.

Thus, a psychiatric diagnosis is an *interpretation* of a person's experience. That interpretation differs systematically for those professionals whose orientation is different. And other social factors—such as clinical specialty, institutional setting, and, most notably in Mrs. Lin's case, the distinctive cultural backgrounds of the psychiatrists—powerfully influence the interpretation. The interpretation is also, of course, constrained by Mrs. Lin's actual experience. Psychiatric diagnosis as interpretation must meet some resistance in lived experience, whose roots are deeply personal and physiological. The diagnosis does not create experience; mental disorder is part of life itself.

But that experience is perceived and expressed by Mrs. Lin through her own interpretation of bodily symptoms and problems of the self, so that the experience itself is always mediated. Because language, illness beliefs, personal significance of pain and suffering, and socially learned ways of behaving when ill are part of that process of mediation, the experience of illness (or distress) is always a culturally shaped phenomenon (like style of dress, table etiquette, idioms for expressing emotion, and aesthetic judgments). The interpretations of patient and family become part of the experience. Furthermore, professional and lay interpretations of experience are communicated and negotiated in particular relationships of power (political, economic, bureaucratic, and so forth). As a result, illness experiences are enmeshed in and inseparable from social relationships.

When a psychiatric diagnosis is made, these aspects of social reality are implied. Diagnosis is a semiotic act in which the patient's experienced symptoms are reinterpreted as signs of particular disease states.[5] But those reinterpretations only make sense with respect to specific psychiatric categories and the criteria those categories establish. All diagnoses share this characteristic, whether the disorder is asthma, diabetes, hyperthyroidism, or depression. However, the signs of psychiatric disorders are more difficult to interpret for two reasons. They are only in part, and even then only for certain disorders, a result of biological abnormality; and psychiatric complaints overlap with the complaints of other ordinary kinds of human misery, e.g., injustice, bereavement, failure, unhappiness.

A psychiatric diagnosis implies a tacit categorization of some forms of human misery as medical problems. Earlier in Western society, what is now labeled depression, a psychiatric disease, may have been labeled as medical disorder (an imbalance in the body's humors), a religious problem (guilt or sinfulness), moral weakness (acedia), or fate (Jackson 1985, 1987). In traditional Chinese medicine, only madness and hysteria were viewed as mental disorders; other problems which we would now call psychiatric were reinterpreted as either manifestations of medical disorder or life troubles owing to the malign influence of gods, ghosts, and ancestors.

In brief, then, though medical diagnosis is taught to medical students and sometimes practiced on patients as a "natural" activity—meaning that symptoms are said to match "underlying" physiological processes—it is anything but natural. What we take a symptom to be is a cultural matter, as is the assumption that a symptom mirrors a single defect in physiological processes. That assumption is not only cultural but naive. One of the most dependable occurrences in clinical care is the practitioner's inability to draw a precise one-to-one correlation between symptom (an experience) and disease diagnosis (an interpretation within a bounded conceptual system). Patients with endoscopic evidence of active ulcer craters in their stomach may have no pain or other symptoms. Conversely, patients with seriously disabling low back pain often have no demonstrable disease. In fact, even when a nerve root is compressed, neurologists cannot say what it is that causes pain (Osterweis et al., eds., 1987, pp. 123–145). There is no direct measurement of pain independent of its subjective experience, and that experience amplifies or dampens or expresses in unpredictable, idiosyncratic ways the symptom pain. The diagnosis of a structural or functional abnormality tells the practitioner little at all about severity of symptoms, functional impairment, or course and treatment response (Feinstein 1987).

Although diagnosis is said to be based on a "hypotheticodeductive" method, in which practitioners test possible diagnostic categories against the patient's symptom story to determine which diagnosis best explains the account and which can be rejected, McCormick (1986) shows that formal

hypothesis testing among competing diagnoses is a great rarity in medical practice. Demystifying diagnosis, this physician reasons that simple recognition—based on knowledge, the conceptual system we have learned to use to order the world, and on practical experience, what we have actually been trained to see and do—is the essence of diagnosis in all branches of medicine. The diagnostic interpretation is a culturally constrained activity (though it is also constrained by brute materiality in experience) in which the practitioner's professional training in a particular taxonomic system for ordering experience renders that experience and its interpretation "natural." "What are we missing," asks the naturalist Stephen Jay Gould (1987, p. 24), "because we must place all we see into slots of our usual taxonomy?" The neophyte clinician frequently demands ever more explicit rules to reliably fit sight into slot; the seasoned practitioner often intuitively knows that the fit is good only insofar as it is therapeutically useful and that what is left out of the slotting of experience may be more useful (and valid) than what is hammered in.

In many societies a psychiatric diagnosis has significance in political and legal arenas. In the former, it may be a reason why someone is judged disabled and found worthy of disability-based welfare support. In the latter, it may alter a citizen's rights and responsibilities. The power of an official psychiatric diagnosis in the modern state derives from its formal status as *the* bureaucratic standard for determining everything from competence to revise a will to access to welfare benefits. Increasingly, contemporary society medicalizes social problems (De Vries et al., eds., 1983). Alcoholism, once a sin or moral weakness, is now a disorder. This is not purely arbitrary. Genetic factors and physiological processes are involved. But those factors and processes need to be regarded in a certain way—say, differently from the way we usually regard blue eyes, baldness, an intolerance of strawberries, or an addiction to pasta—before we call them a disease. The same is true of drug abuse, certain kinds of truancy and delinquency for which children and parents were once held legally responsible to school authorities but which are now relabeled as conduct disorder, and a wide range of the experienced problems of daily living, now called stress syndromes, which to a greater or lesser degree have biological antecedents, correlates, and consequents.

Medicalization—whether seemingly scientifically justified or not—is an alternative form of social control, inasmuch as medical institutions come to replace legal, religious, and other community institutions as the arbiters of behavior. This is not always undesirable. In certain societies medicalization may authorize useful social change that is otherwise politically unacceptable. For example, Stone (1984) has shown that the American disability system has come to medicalize problems of poverty, under- and unemployment, and worker alienation. That is to say, economic downturns, rises in unemployment, and job dissatisfaction translate fairly di-

rectly into increased numbers of individuals filing disability claims, usually for chronic, low-grade problems such as back pain that they previously did not perceive as impeding physical functioning (see Osterweis et al., eds., 1987). The disability program has thereby functioned to redistribute income—a tacit arrangement that our society would not expressly authorize. Alternatively, medicalization may trivialize and deny social problems (e.g., dealing with Mrs. Lin as if her problem was simply a psychiatric or medical disorder, and not the darker side of major social transformations in modern China). The use of psychiatric diagnoses in the Soviet Union and elsewhere to label dissidents as ill so that they can be isolated and disciplined in prison hospitals is perhaps the most notorious current instance of the abuse of medicalization; but the medicalization of the killing of schizophrenic patients and the mentally retarded, which was the prototype for the killing of Jews, under the Nazis must surely stand as psychiatry's darkest hour (Lifton 1986).

The Meaning of Psychiatric Diagnosis to the Psychiatrist

In a brilliant volume, McHugh and Slavney (1986), senior psychiatrists at Johns Hopkins Medical School, describe psychiatric diagnosis in a phenomenological idiom that I suspect most psychiatrists would find compelling.[6] They refer to psychiatric disorders as naturally occurring forms of mental experience that can be observed in much the same way that the natural scientist observes the stratigraphy of mountains, the structures of the cell, or the forms of diseased arteries, rashes, and cancers. The problem of psychiatric diagnosis then becomes a question of verification. Are the forms present or not? McHugh and Slavney describe the two kinds of verification that psychiatric researchers struggle to establish in studies of the prevalence, manifestations, course, and treatment response of particular psychiatric disorders—namely, reliability and validity. Reliability they define as "verification of observations"; it is "the consistency with which one can make an observation . . . [it] is demonstrated by the correlation between the results of observers using the same technique to make that observation" (p. 4). Reliability is documented by the inter-rater correlation coefficient for congruence of diagnosis by psychiatrists trained in the same diagnostic methodology and using the same criteria.

Validity, on the other hand, is the "verification of presumptions," i.e., the verification of the psychiatric categories themselves. McHugh and Slavney correctly note that the "reliability of some psychiatric observations is high". That is to say, psychiatrists can be trained so as to make the same observations. But reliability reveals only that the measurement of the observations is consistent. It does not tell us if the observations are valid, i.e., whether a patient does or does not have an abnormal mental state such as delusions or hallucinations. After all, diagnosticians can be trained so that they are consistent but wrong.

For example, suppose ten North American psychiatrists are trained in the same diagnostic assessment technique and employ exactly the same diagnostic criteria. They are each asked to interview ten American Indians who are in the first weeks of bereavement following the death of a spouse. They may determine with 90 percent consistency (that is nine out of ten times) that the same seven subjects report hearing the voice of the dead spouse calling to them as the spirit travels to the afterworld. That is a high degree of reliability of observation. But the determination of whether such reports are a sign of an abnormal mental state is an interpretation based on knowledge of this group's behavioral norms and range of normal experiences of bereavement. Now it just so happens that in many American Indian tribes auditory experiences of the voices of the spirits of the dead calling to the living to join them in the afterworld are an expected and commonly experienced part of the sadness and loss that constitute the process of bereavement. This experience does not portend any dire consequences such as psychosis, protracted depression, or other complications of bereavement. Thus, to systematically interpret these normal auditory experiences in this cultural group as "hallucinations," with all that term connotes of abnormality, is an example of reliability without validity. Yet this is often done. I myself have been asked on four occasions to diagnose American Indian bereaved who were undergoing this culturally normative experience as psychotic, and thereby certifiable, by physicians who had made this invalid inference of hallucinations from normal sensory experience.[7]

The problem lies in the positivist bias of most psychiatrists. For McHugh and Slavney, and most of us who have undergone the empiricist training in medical school, observations are direct representations of reality. A word, e.g., "hallucinations" or "delusions," points to an empirical entity, e.g., "abnormal mental state in the world." Advances in effective psychiatric treatment of specific disorders and recognition that clusters of symptoms and signs have the same prognosis not surprisingly encourage the view that depression, schizophrenia, and phobias are "things" in the real world. The picture is more complex. A word, after all, is a sign that signifies a meaningful phenomenon. That phenomenon, as noted above, exists in a world mediated by a cultural apparatus of language, values, taxonomies, notions of relevance, and rules for interpretation. Thus, observations of phenomena are judgments whose reliability can be determined by consistency of measurements but whose validity needs to be established by understanding the cultural context. Perception is theory-driven. The voice of a dead spouse is a hallucination (meaning abnormal sensory process) among most North Americans, for whose reference group the experience is not

normative (though perhaps this is not true for some bereaved children—see Egdell and Kolven 1972; and Balk 1983). But it is a normal experience of bereavement among members of many American Indian tribes. The term "hallucination," when used in its clinical sense to mean an abnormal percept, is an invalid interpretation for these individuals.

Validation of psychiatric diagnoses is not simply verification of the concepts used to explain observations. It is also verification of the meaning of the observations in a given social system (a village, an urban clinic, a research laboratory). That is to say, observation is inseparable from interpretation. Psychiatric diagnoses are not things, though they give name and shape to processes involving neurotransmitters, endocrine hormones, activity in the autonomic nervous system, and thoughts, feelings, and behaviors that show considerable stability. Rather, psychiatric diagnoses derive from categories. They underwrite the interpretation of phenomena which themselves are congeries of psychological, social, and biological processes. Categories are the outcomes of historical development, cultural influence, and political negotiation. Psychiatric categories—though mental illness will not allow us to make of it whatever we like—are no exception.

If the cross-cultural perspective sharply raises the issue of validity, it surely does not resolve how it is to be decided. Clearly, validity cannot be a matter of pure subjectivity or complete relativity: the disease and its experience also constrain what diagnosis is valid. What are the criteria we can pose, then, for validity of diagnostic categories applied cross-culturally (i.e., how will we recognize a valid interpretation when we see it)? What techniques can be specified that are likely to produce cross-culturally valid diagnoses? Anthropology poses the question, but offers only a tentative and quite modest answer: assuring the validity of psychiatric diagnoses should involve a conceptual tacking back and forth between the psychiatrist's diagnostic system and its rules of classification, alternative taxonomies, his clinical experience, and that of the patient, which includes the patient's interpretation. Validity is the negotiated outcome of this transforming interaction between concept and experience in a particular context. Thus, validity can be regarded as a type of ethnographic understanding of the meaning of an observation in a local cultural field.

Let us return to the diagnosis of Mrs. Lin's disorder. For her Chinese internists and psychiatrists, the disorder is neurasthenia—a putative "chronic malfunction" of the cerebral cortex associated with nervousness, weakness, headaches, and dizziness, thought to be common among "brain workers" and to have psychosocial as well as biological causes. But it is held to be a physical illness and therefore neither conveys the marked stigma Chinese attribute to mental illness nor implies personal accountability for the associated physical impairment or emotional distress. The way in which Mrs. Lin presents her symptoms is also influenced by the

category neurasthenia, which is not only a technical psychiatric taxonomic entity in China but one widely understood in the popular culture. Mrs. Lin's perception of her symptoms selects out and lumps together those symptoms that are familiar and salient to her, namely the ones that fit the popular blueprint of neurasthenia. This practice is reinforced by the relatives, friends, and practitioners to whom she tells the story of her illness, who attend to and emphasize precisely those symptoms that they expect to be present in the neurasthenic syndrome. Thus, Mrs. Lin's symptom report is already an interpretation and therefore a diagnosis.

For myself, the North American psychiatrist who interviewed Mrs. Lin, neurasthenia was not a diagnostic possibility. Ironically "neurasthenia," a term coined by the New York neurologist George Beard in 1869 to describe a disorder he called the "American Disease" because of its presumed prevalence in the United States, was formally expunged from the American Psychiatric Association's latest official Diagnostic and Statistical Manual, Third Edition (DSM-III), in 1980.[8] It had ceased being an acceptable professional term several decades before. In the same year DSM-III's rejection of the term meant neurasthenia was no longer a disease in the United States, I conducted a study of 100 neurasthenic patients in the outpatient psychiatry clinic at the Hunan Medical College. I showed that most of these patients could be rediagnosed, using a standard North American psychiatric protocol translated into Chinese together with DSM-III diagnostic criteria, as cases of major depressive disorder (Kleinman 1986). But there was a rub. Unlike the great majority of chronically depressed patients, these depressed patients responded only partially to antidepressant medication. Although many of the symptoms associated with depression improved, their chief somatic complaints and medical help seeking ended only when they were able to resolve major work and family problems (Kleinman and Kleinman 1985; Kleinman 1986).

I concluded that there were several ways to explain these findings. Neurasthenia might represent culturally shaped illness experience underwritten by the disease depression. The biologically based disease responded to the "therapeutic trial" of drugs; the illness experience ended only when powerful social contingencies "conditioning" the sick role behavior were removed. Chronic pain and other chronic conditions associated with depression have been shown to have a similar treatment response. Once the illness behavior becomes chronic, treatment of the depression may nor may not remove the symptoms of depression, but the illness behavior persists (Katon et al. 1982). Alternatively, both neurasthenia and depression might be regarded as the products of distinctive Chinese and American professional psychiatric taxonomies. In that sense, the experience that both psychiatric systems mapped might be thought of as a case solely of the psychobiology of chronic demoralization, and the mapping itself as a medicalized turning

away from the social sources of human misery. In this alternative formulation, the psychiatric diagnosis does not point toward the solution. Rather it disguises the problem.

Other schools of psychiatrists might interpret Mrs. Lin's case and the 100 cases in the Hunan sample drawing on the diagnostic systems of psychoanalytic, behavioral, or other approaches to psychiatry. The World Health Organization (WHO) sponsors a diagnostic system, the International Classification of Disease, Ninth Revision (ICD-9), which does include neurasthenia as an official diagnosis. Although ICD-9 is not used in the United States, it is used in much of the world. Neurasthenia is no longer widely diagnosed in North America, South America, or Western Europe, but it is still a popular diagnosis in Eastern Europe, China, and several Southeast Asian societies. Furthermore, the symptoms and behaviors neurasthenia labels in those societies, which are much like those described in Beard's classic definition, are still common in the United States, despite the fact that the term "neurasthenia" lacks coherence in the North American popular culture. In the West now, new diagnostic labels are employed which emphasize distinctive aspects of this syndrome: "depressive disorder," "anxiety disorder," "somatization disorder," "chronic pain syndrome," and in the North American popular culture, "stress syndrome." A characteristic of these newer terms is that sometimes they describe syndromes that are predominantly bodily, like neurasthenia in China and in nineteenth-century New York, and other times clusters that are predominantly psychological. The presumption is that psychopathology creates both varieties of symptoms. (In this sense, unlike neurasthenia, these disorders, which imply psychosomatic factors, are not regarded as legitimate physical disorders. For that reason chronic viral disorders, like hypoglycemia and other putative physical disorders a decade ago, are the currently fashionable exemplars of "real" disease used to legitimate psychosomatic conditions.) Both forms of symptoms are common in the West, but the overtly psychological variety is decidedly uncommon in most non-Western societies. This important cross-cultural finding—often referred to in the West ethnocentrically as the *somatization* of mental illness in non-Western cultures—I will return to in the next chapter when I discuss the evidence for cross-cultural differences in psychopathology.

The Category Fallacy

If psychiatrists in the United States were to diagnose North American patients similar to Mrs. Lin as cases of neurasthenia, their decision would be seen by their peers as an invalid anachronism. The reification of one culture's diagnostic categories and their projection onto patients in another culture, where those categories lack coherence and their validity has not

been established, is a category fallacy (Kleinman 1977). Obeyesekere (1985) offers a telling example. Suppose, he suggests, a psychiatrist in South Asia, where semen loss syndromes are common, traveled to the United States, where these syndromes have neither professional nor popular coherence. Let us imagine that this South Asian psychiatrist has first operationalized the symptoms of semen loss in a psychiatric diagnostic schedule, translated this interview protocol into English, had other bilingual persons translate it back into the original language to check the accuracy of the translation, adjusted those items that were mistranslated, and then trained a group of American psychiatrists in its use and established a high level of consistency in their diagnoses. Using this schedule, he could derive prevalence data for "semen loss syndrome" in the United States. But would these findings have any validity in a society in which there are neither folk nor professional categories of semen loss and in which semen loss is not reported as a disturbing symptom?

This egregious example of the category fallacy is amusing but deplorable. Regrettably, much of cross-cultural psychiatry has been conducted in a rather similar manner, though with one important difference. By and large, cross-cultural studies in psychiatry are carried out by Western psychiatrists (or by members of the indigenous culture who are trained either in departments of psychiatry dominated by Western paradigms or in the West itself) working in the non-Western world.

Dysthymic disorder in DSM-III, or neurotic depression in ICD-9, may be an example of a category fallacy. Chronic states of depression associated with feelings of demoralization and despair have been prominent in the West since the time of Hippocrates (Jackson 1986). Yet in Chinese and other non-Western societies they have not received a great deal of attention. They are influential in the West, especially for the more affluent members of society. However, dysthymia would seem to be an instance of the medicalization of social problems in much of the rest of the world (and perhaps often in the West as well), where severe economic, political, and health problems create endemic feelings of hopelessness and helplessness, where demoralization and despair are responses to actual conditions of chronic deprivation and persistent loss, where powerlessness is not a cognitive distortion but an accurate mapping of one's place in an oppressive social system, and where moral, religious, and political configurations of such problems have coherence for the local population but psychiatric categories do not. This state of chronic demoralization, moreover, is not infrequently associated with anemia and other physiological concomitants of malnutrition and chronic tropical disorders that mirror the DSM-III symptoms of dysthymic disorder (e.g., sleep, appetite, and energy disturbances). In such a setting, is the psychiatrist who is armed with a local translation of the major North American diagnostic instruments (e.g., the Diagnostic Interview Schedule or the Schedule of Affective Disorders and

Schizophrenia) and who applies these to study the prevalence of dysthymic disorder any different from his hypothetical Bangladeshi colleague studying semen loss in mid-town Manhattan? Clearly, great care must be taken before applying this diagnostic category to assure that its use is valid.

For the psychiatric epidemiologist, it is crucial to distinguish a case of a disorder from a person with distress but no disorder. Depression, after all, can be a disease, a symptom, or a normal feeling. Operational definitions that specify inclusion and exclusion criteria are what enable the epidemiologist to proceed. In making the distinction between distress and disorder, taxonomy can become entangled in its own decision rules. For patients with loss of energy due to malaria, appetite disturbance and psychomotor retardation owing to the anemia of hookworm infestation, sleeplessness associated with chronic diarrheal disease, and dysphoria owing to poverty and powerlessness, labeling these four somatic symptoms and one emotion the diagnostic criteria of major depressive disorder is the difference between becoming a case of the disease depression and an instance where depression is a symptom of distress due to a socially caused form of human misery and its biological consequences. Neither DSM-III nor ICD-9 was created with such problems in mind. But they are applied in such settings. The upshot is both a distorted view of pathology and an inappropriate use of diagnostic categories.

As we shall see in the next chapter, there is overwhelming evidence that certain psychiatric diagnoses are valid worldwide—e.g., organic brain disorders, schizophrenia, manic-depressive psychosis, certain anxiety disorders, and perhaps major depressive disorder. But we have substantial reason to doubt whether other psychiatric diagnoses currently popular in the West—e.g., dysthymic disorder, anorexia nervosa, agoraphobia, and personality disorders—are valid categories for other societies.

There is, however, good justification to apply psychiatric diagnoses with rigor and precision. Certain psychiatric conditions are treatable; and without effective treatment, they lead to pain, suffering, disability, considerable expense, and even death. Effective treatment and prevention require a usable diagnostic system. On the other hand, attempts to create airtight systems of diagnoses are ineffective, costly, and dangerous. Diagnostic systems do have unintended consequences, one of which is to serve bureaucratic interests of social control that may not be healthy for patients. There are also intended consequences of diagnostic systems, such as providing official listings for third-party reimbursement, legal procedures, and disability determinations that go beyond the technical needs of the diagnostician but are essential for the patient and the broader society. Both intended and unintended consequences shape the diagnostic system. For example, DSM-III is so organized that every conceivable psychiatric condition is listed as a disease to legitimate remuneration to practitioners from private medical insurance and government programs.

Perhaps the most useful contribution of cultural analysis to psychiatry is to continually remind us of these dilemmas. Cross-cultural comparison, appropriately applied, can challenge the hubris in bureaucratically motivated attempts to medicalize the human condition. It can make us sensitive to the potential abuses of psychiatric labels. It encourages humility in the face of alternative cultural formulations of the same problems, which are viewed not as evidence of the ignorance of laymen, but as distinctive modes of thinking about life's troubles. And it can create in the psychiatrist a sense of being uncomfortable with mechanical application of all too often taken-for-granted professional categories and the tacit "interests" they represent. There is, thank goodness, an obdurate grain of humanness in all patients that resists diagnostic pigeonholing. Most experienced psychiatrists learn to struggle to translate diagnostic categories into human terms so that they do not dehumanize their patients or themselves. Yet, the potential for failure in this core clinical skill is built into the very structure of diagnostic systems. An anthropological sensibility regarding the cultural assumptions and social uses of the diagnostic process can be an effective check on its potential misuses and abuses. Irony, paradox, ambiguity, drama, tragedy, humor—these are the elemental conditions of humanity that should humble even master diagnosticians.

Rethinking Psychiatry

From Cultural Category to Personal Experience

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