

Correspondence

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Culture-specific psychiatric illness?

It is depressing that an editorial in a major psychiatric journal can still maintain that "there is no solid evidence for a real difference in the prevalence of common psychiatric disorders across cultures" (Cheng, 2001). Cheng collapses the socioculturally determined understandings that patients bring to bear on their active appraisal of their predicament and on their expressions of distress and help-seeking to the term "illness behaviour". The (Western) psychiatrist is to see through this mere packaging to the psychopathology within, which he knows to be universal and the 'real' problem. Cheng goes on to assert that disturbed people in "less-developed" societies present somatically because of their "limited knowledge of mental disorders". There is a distinct echo here of the imperial era, when it was pressed upon indigenous people that there were different types of knowledge and that theirs was second-rate. Sociocultural and sociopolitical phenomena were framed in European terms and the responsible pursuit of traditional values was regarded as evidence of backwardness (Summerfield, 1999).

All of psychiatry is culture-bounded, not just a few syndromes in the DSM or ICD: even presentations by patients with organic disorders are embedded in particular 'lifeworlds' and local forms of knowledge. Western psychiatry is but one among many ethnopsychiatries. Cheng commits what Kleinman (1987) called a category fallacy: the assumption that because phenomena can be identified in different social settings, they mean the same thing in those settings.

The World Health Organization is falling into the same trap in its claims that 'depression' is a worldwide epidemic that within 20 years will be second only to cardiovascular disease as the world's most debilitating illness. The implication of such medicalisation is to deflect attention away

from what millions of people might cite as the basis of their suffering, for example, poverty. In whose interests, apart from the pharmaceutical industry's, can this be?

We need a psychiatry that recognises the limitations of a technical approach and sees acknowledgement of sociocultural and political contexts as an ethical obligation (Bracken & Thomas, 2001). If Cheng were to see this as a challenge to the whole project – to (Western) psychiatry as a global enterprise propagating supposedly universal and morally neutral facts – then so be it.

Bracken, P. & Thomas, P. (2001) Postpsychiatry: a new direction for mental health. *BMJ*, **322**, 724–727.

Cheng, A. T. A. (2001) Case definition and culture: are people all the same? *British Journal of Psychiatry*, **179**, 1–3.

Kleinman, A. (1987) Anthropology and psychiatry. The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, **151**, 447–454.

Summerfield, D. (1999) A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science and Medicine*, **48**, 1449–1462.

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Andrew Cheng's contribution (2001) to the debate on the universality *v.* cultural particularity of psychopathology follows the conventional distinction between the pathogenic form of the illness, presumed to be biological, and its pathoplastic content of psychological or social origin (Littlewood, 1996). In his rephrasing, content is merely the "subjective complaint" or "illness behaviour", form the "objective symptoms". He then dissects such culture-specific patterns as koro into the 'real' illness (panic attacks) and the 'false belief' apparently found in people of "low intelligence" with "limited knowledge of mental disorders", thus proving his case.

His procedure is an act of faith in the possibility (and usefulness) of this Kantian distinction, which has been an article of psychiatric belief since Kraepelin and Birnbaum (Littlewood, 1990). While possibly of some utility for the major psychoses where we may trace some biological aetiology, it seems bizarre to assume that we will find universality in all patterns of psychiatric interest. Eating disorders, multiple personality disorder, overdosing, shoplifting, agoraphobia, school refusal, to mention some Western patterns alone: each is constructed by context and meaning as it is constructed by biological difference. Could we consider school refusal as a universal pattern in the absence of elementary schools in certain societies? What would be left here without social context? What then our analogues of school refusal?

To assert that the business of psychiatry is only the biological (and why should that presume the universal?) is to restrict our discipline to veterinary science. To ignore meanings as potentially causal is to offer an etiolated psychopathology, one presumed to be 'scientific' in advance (Kleinman, 1988). To offer a general model of all psychopathology with fixed relations between the social and the biological is certainly non-empirical, and only potentially redeemed if we then exclude the social *a priori* from any potential patterns. To search for universality is doubtless laudable: to presume it is not.

Cheng, A. T. A. (2001) Case definition and culture: are people all the same? *British Journal of Psychiatry*, **179**, 1–3.

Kleinman, A. (1988) *Rethinking Psychiatry: From Cultural Category to Personal Experience*. New York: Free Press.

Littlewood, R. (1990) From categories to contexts: a decade of the 'new cross-cultural psychiatry'. *British Journal of Psychiatry*, **156**, 308–327.

— (1996) Psychiatry's culture. *International Journal of Social Psychiatry*, **42**, 245–268.

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Author's reply: Littlewood states, "In his rephrasing, content is merely the 'subjective complaint' or 'illness behaviour', form the 'objective symptoms'". This is a misunderstanding of what I have tried to emphasise in my editorial. One of the major points in my work is that the patient's subjective