On the Wisdom of Considering Culture and Context in Psychopathology

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Since the advent of the "new cross-cultural psychiatry" in the late 1970s (Kirmayer, 2006; Kleinman, 1977; Littlewood, 1990), psychiatric researchers have distinguished between the historical enterprise of exporting conventional categories of "mental disorder" throughout the world's diverse cultural communities for the purposes of comparative study, and the more recent commitment to examining the cross-cultural viability and coherence of such categories within culturally local frameworks of distress, illness, and dysfunction (Kirmayer, 2007a). Such reflexive awareness concerning the Western cultural foundations of the categories and constructs used in cross-cultural studies of psychopathology parallels a broader conceptual and methodological revolution in the social sciences (Rabinow & Sullivan, 1987). This reflexive stance has encouraged attention to the ways in which science and technical practices are embedded in local and international systems of power and knowledge, and has urged caution in generalizing or applying dominant approaches to disparate cultures and communities.

And yet, as helping professions rooted in an understanding of the human condition, psychiatry and psychology aim for theories of psychopathology that can be used across social and cultural contexts. An international diagnostic nosology should provide a common language allowing psychiatrists everywhere to exchange knowledge about specific patients, have ready access to current technical approaches, and contribute to the advance of psychiatric science. Unfortunately, this project of a global scientific psychiatry tends to view culture as a distraction from the project of developing a body of universal knowledge. That is, cultural diversity becomes an obstacle to scientific research and delivery of care, or else a matter of trivial differences—of "window dressing" on the essential core of universal human experience that might ground a universal nosology.

This more dismissive view of the relevance of culture for world psychiatry is part of the legacy of European empire, in that it assumes that the pertinent categories, concepts, principles, and practices—constructs that emerged almost exclusively from certain subpopulations or social strata within a handful of European and North American societies—constitute a universal, transcen-

dent, ahistorical, and "culture-free" basis for recognizing "natural kinds" (i.e., the categories that are immediately given to perception or that can be readily discerned by "carving nature at its joints") within the domain of psychopathology. This ethnocentrism is also evident in the way non-Western cultures are frequently construed by Westerners: There is a tendency to dichotomize self and other, to view the world as "us and them." We have *knowledge*, while they have *beliefs*; we see things as they truly are, while they are deluded by their stubborn traditions and superstitions. The imperialist roots of this thinking are evident in the resultant asymmetries in valuing truth claims: European American epistemological practices yield transcendent technical knowledge, while other epistemological traditions yield mere folk knowledge comprising beliefs rather than truths about the world. In actual fact, however, the concepts and categories of contemporary psychiatry are not transcendent, culture-free outcomes of objective observation and scientific research; instead, they carry forward the legacy of their own cultural histories (Gaines, 1992; Mezzich et al., 1999; Mezzich, Kleinman, Fabrega, & Parron, 1996; Young, 1995). To explore this further, we briefly consider the neo-Kraepelinian nosological project before turning to questions about the place of culture within mainstream scientific work on psychopathology.

The Neo-Kraepelinian Vision and the Nature of Contemporary Nosology

The historically contingent nature of the reigning nosology—and thus its salience as a "cultural artifact" (i.e., a creation or product that emerges within a unique time and place)—remains evident despite its increasing circulation and influence around the world. More specifically, modern versions of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM; American Psychiatric Association [APA], 1980, 1987, 1994, 2000) are the products of the neo-Kraepelinian movement that emerged in the 1960s at Washington University in St. Louis and that has dominated psychiatry since the 1970s (Wilson, 1993; Woodruff, Goodwin, & Guze, 1974; Young, 1991).

The Neo-Kraepelinian Vision

Klerman (1978) outlined several commitments of this neo-Kraepelinian movement, including the conviction that the study of psychopathology and its treatments belongs properly within the field of medicine; that mental illnesses/disorders are discrete entities with etiologies that can be discovered principally within the realm of disordered biology (as opposed to the previously dominant mode of explanation, derived from psychoanalysis, that privileged intrapsychic dynamics); that psychiatric research on psychopathology should depend principally on statistical inference in the context of modern scientific methodology; that the progress of science in the context of understanding psychopathology requires extensive concern with the standardization of diagnostic concepts and categories for implementation in research and treatment settings in reliable and valid ways; and that the relationships among and between discrete psychiatric disorders should be represented in scientifically valid classification schemes, with explicit diagnostic criteria for the disorders so classified (see Blashfield, 1984, for discussion and amplification of these commitments). The neo-Kraepelinian concern with standardized categories of disorder (consisting of detailed and relatively explicit criteria with accompanying decision rules for determining category membership) was central to the revolutionary reformulation of psychiatric nosology codified in DSM-III (APA, 1980) and its descendants.

There can be little doubt that cumulative scientific progress in understanding the origins, outcomes, and treatments of psychiatric distress requires some semblance of standardization, in order for independent research findings to coalesce and be built upon in useful ways. In addition, it seems sensible to specify and represent the relationships among and between various kinds of "mental disorders" within some heuristic classification scheme. The challenge is how to select among the almost infinite range of principles that could serve as organizational bases for structuring such a taxonomy (Millon, 1991). Given the fact that psychiatric scientists typically conduct their research within medical contexts, and thus tend to privilege the biological foundations of medi-

cal practice, psychiatric research has emphasized the empirical specification of "underlying pathophysiology" for various conditions and disorders as the sine qua non of the scientific project to advance our understanding of psychopathology. It is important to note, however, that many psychopathologists—especially researchers trained in clinical psychology and the remaining "psy-" disciplines—ardently contest the commitment of the neo-Kraepelinians to biological reductionism, arguing instead that psychopathology may result from emergent psychological or social processes that are not simply reducible to biology (Henningsen & Kirmayer, 2000; Kirmayer & Young, 1999; see also Beutler & Malik, 2002, for recent critiques). Nevertheless, the pursuit of underlying pathophysiology reflects the dominant trend in psychopathology research, as evidenced by the distribution of research funds, journal citations, and professional prestige.

Within the dominant frame of contemporary psychiatry, then, psychopathology is concerned with the fundamental biological processes (i.e., "basic" genetic, anatomical, and physiological processes in complex interactions that are "influenced" by the organism's environment) that go awry in instances of illness or disorder. Such pathophysiology is characterized as "underlying" because the precise means and mechanisms within the brain and body that are presumed to culminate in the reported symptoms or observable signs of psychiatric disorder are elusive and (in almost every instance) unknown. Thus the empirical pursuit of "endophenotypes" and other correlates of underlying pathophysiologies for a wide variety of mental disorders represents the dominant paradigm in the scientific investigation of psychopathology. Finally, within the traditions of scientific medicine, it is presumed that the empirical identification of etiology in the form of distinctive pathophysiology will ultimately *define* the disorders in question—in much the same fashion that modern medicine currently understands Down's syndrome, general paresis, or phenylketonuria in terms of their underlying pathophysiologies.

If the etiological pursuit of underlying pathophysiology characterizes the dominant paradigm in psychopathology research, then the obvious implication for developing a classificatory strategy is to organize the nosology in terms of kinds of pathophysiologies. The dilemma, of course, is that psychopathologists have yet to empirically identify *any* pathognomonic features of a purported mental disorder, much less its definitive pathophysiology. In the interim, the reigning taxonomic strategy depends on grouping taxa by similarities in "phenomenology"[1] (in most instances, based on clusters of symptoms at the syndromal level; see DSM-IV-TR [APA, 2000] for discussion). It is important to recognize that no credible psychopathologist—including the psychiatric scientists who developed the various revisions of DSM—would suggest that the disorders currently classified within DSM are validated constructs that warrant much scientific confidence. Nevertheless, the majority of psychopathologists are confident in the validation strategies described by Robins and Guze (1970) and elaborated by Kendell (1989) for empirically evaluating the merits of purported disorders as viable "hypothetical constructs" (Morey, 1991, drawing upon MacCorquodale & Meehl, 1948). These and other closely related strategies constitute normative science within a neo-Kraepelinian psychiatry.

In sum, although psychopathology researchers acknowledge that the hypothetical constructs contained in even the most recent version of DSM are "splendid fictions" (Millon, 1991, p. 246), most imagine that systematic inquiry within the paradigm just described will one day yield a much less arbitrary nosology that more closely approximates "carving nature at its joints." In response, we simply observe that the promise of the neo-Kraepelinian pursuit of distinctive pathophysiologies for the wide variety of mental disorders remains a matter of *professional faith.* The currently authorized nosological categories, consisting of nearly 300 of Millon's splendid fictions, reflect numerous political, aesthetic, and pragmatic commitments that yield abundant evidence of prescientific or nonscientific arbitrariness—all of which arise as expressions of cultural processes and practices (as indeed does scientific inquiry itself). To illustrate the impact of such processes and practices, we briefly consider the cultural history of one hypothetical construct within the domain of con-

temporary psychopathology—namely, posttraumatic stress disorder (PTSD).

The Cultural Construction of PTSD

The advent of DSM-III saw a movement to attribute a vast array of problems to trauma exposure, gathered together under the umbrella of PTSD. The ensuing years have seen the expansion of this category, which to some extent has absorbed other conditions formerly linked to adverse life events. Conventional histories of this construct suggest that PTSD has afflicted survivors of psychological trauma for millennia (Herman, 1992; Trimble, 1985), and that it has merely awaited discovery in the reports and behaviors of its sufferers by intrepid psychopathologists. In contrast to these seamless accounts, cultural historians have contended that the current conceptualization of PTSD, as both a category of clinical attention and a kind of crippling experience, is rather newly arrived on the historical stage (Hacking, 1996; Lerner, 2003; Leys, 1996, 2000; Young, 1995, 1996a, 1996b). These cultural analysts argue that PTSD, instead of possessing the timeless universality and intrinsic unity assumed in our "received" notions of the disorder, has only recently been "glued together" (Young, 1995, p. 5) from fragmentary shards of theory, politics, and practices spanning more than a century. Analytic attention to cultural processes and practices is therefore relevant not just for charting the varieties of PTSD experience among the world's diverse peoples, but also for grounding our conceptual understanding of the PTSD construct itself as one increasingly prominent category within the early-21st-century classification of psychopathology.

The construct of PTSD singles out the health consequences of the adaptive conditioned fear response to life-threatening danger. Although exposure to the threat of violence, pain, and injury readily gives rise to the specific forms of conditioned emotional response and avoidance learning held to underlie PTSD, this captures only a small part the human response to trauma and virtually never exists in isolation (Kirmayer, Lemelson, & Barad, 2007). The same traumatic events that give rise to PTSD have a wide range of other personal and social effects on biobehavioral systems involving fear, attachment, coherence, hope, identity, and sense of justice (Silove, 1999). The act of singling out a single biobehavioral response as a discrete disorder creates a measure of diagnostic clarity and precision—but, despite a considerable body of research, the extent to which this response should be framed as psychopathology and the degree of correspondence with the actual experience of suffering individuals both remain contested (Konner, 2007).

Even a casual inspection of recent versions of DSM indicates some evolution of psychiatric thought relative to PTSD since its initial incorporation into the official nosology of DSM-III in 1980. For example, the Criterion A definition of the qualifying stressor has changed between versions; the number of symptoms required for clinical inference of the disorder has increased; and the duration of symptoms necessary for diagnosis has ultimately been fixed at 1 month. More illuminating still are the questions and controversies that occupied the PTSD sub-Work Group of the DSM-IV Task Force during preparation of DSM-IV (Davidson et al., 1996). These included how narrowly to define the Criterion A stressor; what duration of symptoms to adopt for distinguishing between normative and pathological reactions to trauma; which subtypes and course specifiers to include; what number of avoidance symptoms to require for a diagnosis; whether to classify PTSD as an anxiety disorder or a dissociative disorder, or within a new class of trauma-related disorders; how to make sense of the high rates of comorbidity between PTSD and other mental disorders; and whether to include a new form of pathological posttraumatic response indicated by "extensive characterological changes" (p. 592) attributed to repeated and prolonged trauma. In some instances, the associated empirical investigation known as the PTSD Field Trial (Kilpatrick et al., 1998) obtained data related to these questions (e.g., neither broad nor narrow definitions of the qualifying stressor appeared to significantly alter sample prevalence of the disorder), but in most instances such data, even when obtained, were insufficient to resolve these questions (e.g., reduction of the required avoidance symptoms increased PTSD prevalence, and yet the overall implications of this

increase remained unclear in the face of delimiting sample characteristics).

For the purposes of our argument, the most important acknowledgment is that data alone will never be adequate to resolve these and many other similar questions and controversies surrounding PTSD (see McNally, 2003, for an elaboration), *as long as* independent and reliable measures of distinctive pathophysiology or specific etiology remain unestablished for the disorder. In fact, as the cultural historians suggest, it seems debatable whether meaningful human responses to "traumatic" experience are even of the "natural kind" variety that might be amenable to scientific demonstrations of distinctive pathophysiology or confirmations of specific etiology. As a result, for a hypothesized syndrome currently without *any* pathognomonic indicators that might unify diverse patient profiles, decisions regarding conceptualization of the disorder at this stage of inquiry are rendered largely by expert consensus (sometimes with recourse to data, but often not). Such consensus is made and unmade in *cultural* terms, through enduring and recognizable "logics" of expertise, argument, inquiry, and influence. Nowhere was this consummation of expert consensus more evident than in the historical events surrounding the initial inclusion of PTSD within DSM-III in 1980.

According to Scott (1990), PTSD was born of an unusual political alliance between psychiatrists such as Robert Lifton and Chaim Shatan and activists affiliated with Vietnam Veterans Against the War (VVAW) beginning in the late 1960s. This alliance's escalating campaign for medical recognition of "post-Vietnam syndrome" found footing in a 1975 meeting with psychiatrist Robert Spitzer, the architect of DSM-III, at the Anaheim convention of the American Psychiatric Association. As Scott recounts, Spitzer there dismissed the alliance's proposal for inclusion of the new syndrome, explaining that psychiatric researchers John Helzer and Lee Robins at Washington University had demonstrated with their data that the problems of returning Vietnam veterans were already subsumed under existing disorders (major depression, substance use disorder, etc.). Spitzer challenged the alliance to provide contradictory evidence. Later that year, following additional lobbying, Spitzer agreed to form a task force on the issue and invited alliance members Lifton, Shatan, and Jack Smith (a VVAW activist) to join himself and two other psychiatrists on the official Advisory Committee on Reactive Disorders. With Spitzer's attention frequently drawn elsewhere, according to Scott, the alliance members reasoned that he could be most effectively persuaded to include the syndrome if fellow committee member Nancy Andreasen, then a specialist in treating patients with burns, was first to be convinced of the merits of their cause. Despite ongoing opposition from the Washington University researchers, Andreasen and Spitzer eventually accepted that combat veterans were probably suffering from a distinct psychiatric illness. Given the limited empirical literature available at the time, this recognition depended principally on a series of compelling case studies, presented by outsiders to the psychiatric establishment, including the only member of any DSM-III advisory committee not to have obtained a graduate degree.

In sum, this alliance of "radical" psychiatrists and retired soldiers obtained official recognition of PTSD "because they were better organized, more politically active, and enjoyed more lucky breaks than their opposition" (Scott, 1990, p. 308). Of course, the implications of this watershed historical moment would be difficult to overemphasize. As Scott has observed, official recognition by the American psychiatric establishment accorded PTSD the status of "objective knowledge," which in turn undergirds what people experience as "objective" reality: "each new clinical diagnosis of PTSD, each new warrantable medical insurance claim, each new narrative about the disorder reaffirms its reality, its objectivity, its 'just thereness' " (p. 308). Such reaffirmations of objectivity are possible only if our perspective is fundamentally ahistorical and deeply inattentive to cultural processes and practices, the result of which is the *reification* of a provisional psychiatric construct for which pathophysiology and etiology remain unknown. And, in an ironic twist, such instances of unwarranted reification actively create culture by virtue of prescribing novel forms of illness experience, even as they disavow the relevance of culture for the nosological project.

Unwarranted reification represents a significant liability for any scientific endeavor, including the empirical opportunities and theoretical possibilities that remain unacknowledged and unexplored, owing to the premature foreclosure of conceptual alternatives. Such conceptual alternatives to contemporary PTSD are again suggested in the work of the cultural historians, who chart the rise of modern notions of "trauma" alongside late-19th-century investigations of hysteria, dissociation, and hypnosis. Ruth Leys (2000) asserts that our conceptualization of trauma and its pathologies continues to vacillate between two historical paradigms: mimetic theory, in which the symptoms of trauma are held to involve a kind of unconscious imitation of the original traumatic event, generally through dissociative mechanisms; and antimimetic theories, in which the posttraumatic symptoms are more or less direct consequences of the violent threat or assault. The dilemma is that mimesis can reflect pathological processes mediated by mechanisms of repression or dissociation in memory, or instead can be created factitiously by similar processes of recollection and recall (Young, 2007). Antimimetic theories circumvent this problem by positing psychophysiological effects of trauma (unmediated by the sufferer's own agency or unconscious dynamics) on subsequent symptoms. The so-called "memory wars" of the 1990s perhaps most clearly illustrated this paradigmatic tension (Crews, 1995). Both theories are represented within DSM-IV by the inclusion of PTSD (with a decided "antimimetic" deemphasis of attendant dissociative phenomena) and dissociative identity disorder (a mimetic pathology with a clear emphasis on purported traumatic etiology [Gleaves, 1996; Hacking, 1995b]); the former diagnosis has garnered current respectability within scientific psychiatry, while the latter has not.

In addition, Allan Young (1996a) observed that since their inception, the posttraumatic pathologies reported by survivors of 19th-century railway accidents were difficult for physicians to differentiate from neurological insult, neurotic disposition (leading to trauma-related "hysteria" and other "functional" disorders), or malingering (in pursuit of monetary damages). Young then raised the uncomfortable question of whether traumatic experience in fact caused the PTSD symptoms experienced by the combat veterans in his study, or whether these veterans only later attributed the cause of their long-standing symptoms to previous trauma in post hoc fashion as a direct response to treatment discourse. These concerns continue to trouble the field, insofar as psychopathologists have come to acknowledge the etiological importance of some preexisting "phenotypic expression of vulnerability" in PTSD (Yehuda & McFarlane, 1995) and to "worry" about recent evidence suggesting that a substantial proportion of Vietnam veterans—perhaps as many as 75%, as reviewed by McNally (2003)—have received disability payments for PTSD or have taken part in research studies as "cases" of PTSD, even though they may never have actually experienced combat (Frueh et al., 2005).

Even such brief attention to the cultural history of trauma and its pathologies serves to remind us that, far from the timeless universality and intrinsic unity frequently ascribed to the diagnostic entity, PTSD is a construct of rather recent invention. Certainly humans throughout history have responded to extremely distressing events with extreme distress. Such distress was undoubtedly evidenced through posttraumatic changes in individual cognition, emotion, and behavior. In our particular historical context, it would appear that Westerners (and increasingly the rest of the world as well, especially individuals making bids for international asylum to escape war, torture, and oppression) experience such distress in the increasingly popular genre of PTSD (Pole, Gone, & Kulkarni, 2008). The notion of PTSD serves these social and political functions, which in turn reinforce its coherence as a discrete entity, but this coherence is purchased at the expense of attention to a wide range of other individual responses to trauma. For every nightmare, flashback, amnesia, and exaggerated startle response currently assessed in traumatized patients, the avolition, weakness, headache, nausea, giddiness, photophobia, palpitations, paraesthesias, paralyses, double vision, altered posture, unsteady gait, feeble pulse, pressured speech, loss of appetite, and shortness of breath that characterized 19th-century pathological responses to psychological trauma (Kinzie & Goetz, 1996; Young, 1996a) have fallen by

the wayside. And yet many of these symptoms may continue to be prominent features of posttraumatic distress in diverse cultural settings (Kirmayer, 1996). In short, PTSD as currently configured is a malady of our time, emergent from and dependent upon the same cultural processes and practices that actively constitute contemporary life.

Implications for Cultural Analysis

This brief foray into the origins of PTSD as a nosological category and pathological construct raises questions about its claim to be a timeless, culturally universal entity. While scientific methods hold the prospect of refining our knowledge of how the world works, at any point in time scientifically derived knowledge remains an approximation that incorporates culturally and historically contingent features reflecting the origins of our constructs and the contexts of their use (Collins & Pinch, 1993). In the case of psychiatric nosology, we might consider that this cultural and historical embedding is not a defect or limitation of current scientific knowledge, but a necessity, since psychiatric distress, like all human experience, takes shape from cultural particulars. Psychiatric disorders reflect the outcome of interactions between biological processes and a social surround mediated by psychological mechanisms over the developmental trajectory of a human lifespan. The notion that a comprehensive or complete nosology can be created without regard to culture and context, therefore, can be sustained only by adopting a reductionist perspective that minimizes or ignores the fact that human beings are fundamentally social and cultural beings. Nevertheless, such reductionism is frequently embraced and promoted in the name of a scientific psychopathology, based on the assumption that modern psychiatry pursues transcendent understanding of disorders that exist in the world as natural kinds. In other words, the contemporary recognition of flashbacks and amnesia as symptoms of PTSD, as opposed to photophobia and double vision, is justified on the basis that recent systematic investigations have yielded historical progress in our approximation of the natural kind known as PTSD. But what are the conceptual grounds for presuming that PTSD or any other DSM disorders are natural kinds as opposed to "human kinds"—that is, intentional categories that emerge from our social institutions, knowledge, and practices?

Natural Kinds and Intentional Categories

In 1980, anthropologist and psychiatrist Arthur Kleinman (1986) conducted a landmark study in Hunan, China, that shed light on the universality of categories of common mental disorders. Kleinman studied a group of patients who had received the diagnosis of neurasthenia (*shenjing shuairuo*)—a syndrome marked by somatic complaints such as headache, fatigue, dizziness, and muscle tension, which was a common form of distress routinely diagnosed by Chinese psychiatrists in clinical settings. Neurasthenia (or "nervous weakness") was originally described by the American neurologist George Beard in the late 1800s and soon became a common diagnosis worldwide (Beard, 1869). After the 1920s, the popularity of neurasthenia waned in the West as it was gradually replaced by other construals of psychopathology, most recently clinical depression. Nevertheless, neurasthenia persisted as a professional diagnostic label and a mode of illness experience throughout China up to the 1990s (Lee, 1998).

Applying the diagnostic criteria from the DSM to 100 Chinese patients diagnosed with neurasthenia, Kleinman (1986) determined that the vast majority of these individuals met criteria for major depressive disorder. When they were treated with tricyclic antidepressants, most patients showed some improvement in their symptoms of depression; however, many continued to see themselves as suffering from neurasthenia, pointing to symptoms of depleted energy and other somatic symptoms or difficulties in their lives, which they attributed to their catastrophic experiences during the Cultural Revolution. Instead of concluding that Chinese neurasthenia was identical to clinical depression, Kleinman argued that neurasthenia and depression were in fact distinct forms of distress that did not always co-occur among Chinese patients. Subsequent work has borne this out (Zheng et al., 1997). Nevertheless, drawing on Eisenberg's (1977) differentia-

tion between subjective illness experience and objective disease process, Kleinman assumed that both neurasthenic and depressive syndromes were superficially divergent expressions of the same underlying disease: a "universal core depressive disorder" (1986, p. 66). In short, for Kleinman, neurasthenia was a somatized form of an "underlying" depressive disease. As a folk and professional category, and as a cultural "idiom of distress," neurasthenia had its own sociomoral uses and implications. Kleinman emphasized this sociomoral dimension of experience (though he diplomatically downplayed the continuing role of political repression), but was largely uninterested in neurasthenia as a psychopathological construct for which one might seek to understand underlying mechanisms.

In a critique of Kleinman's report, psychological anthropologist Richard Shweder (1988) noted an unresolved tension in the study's conclusions between a positivist and a constructivist perspective on the diagnostic problem at hand. According to Shweder, neopositivists remain interested in discovering "natural kinds," those phenomena that "exhibit a causation independent of what they mean to us, independent of our involvement with them, independent of our experience with them or evaluation of them, independent of our aesthetic or emotional response to them" (p. 488). In contrast, he continued, constructivists remain interested in discovering "intentional categories," those phenomena that "exhibit whatever causation they may have by virtue of what they mean to us, by virtue of our conceptions and representations of them and reactions to them" (p. 488). Natural kinds thus include such phenomena as trisomy 21 and dopamine. Intentional categories may include such phenomena as psychopathic deviance or *la belle indifférence*.[2]

While Kleinman explicitly adopted a constructivist perspective for many of his analyses of Chinese neurasthenia, Shweder worried about Kleinman's characterization of this syndrome as somatized depression: Could not depression just as easily be construed as a psychologized form of neurasthenia? Shweder wondered what rationale might be offered in support of Kleinman's clear preference for a depression-centered discourse: "If a disease process is different from an illness experience and if depression is a disease process (as well as an illness experience), then what precisely is that depressive disease process that is other than an illness experience, and how do we know that neurasthenia is a somatized version of it?" (1988, p. 494). Here Shweder laid bare the fundamental problem of cross-cultural analysis in psychopathology research—namely, the challenge of determining how we might reconcile divergent frames of reference, modes of representation, and modalities of experience that give rise to diverse patterns of dysfunctional or disordered experience and expression within and between culturally distinctive communities throughout the world. One implication of the distinction between natural kinds and intentional categories is that while attention to cultural processes and practices throughout the diverse regions of the world may be helpful and illuminating for investigation of disorders of the "natural kinds" variety, such attention is absolutely indispensable for investigation of disorders of the "intentional categories" variety. In other words, if human pathological reactions to traumatic experiences are indeed widely contingent on time, locale, and ethos, then conceptualizing, classifying, investigating, and treating such reactions are heavily dependent on the historically and culturally contingent frameworks of meaning that mediate such pathological experiences. But what are the grounds for imagining that such cultural frameworks of meaning might actually mediate the experience of many forms of psychopathology?

The Depth and Sweep of Culture: The Case of Emotional Experience

A robust cross-cultural psychopathology takes as its point of departure the recognition of the *co-constitution* of mind and culture. More specifically, cultural psychologists and psychiatrists are concerned with the manner in which human beings—and the cultures they dynamically and interactively construct and reproduce—give rise to "culturally constituted persons" who are both producers and products of the intentional worlds they inhabit (Shweder, 1991). For our purposes, "culture" may be understood as the socially patterned and historically reproduced systems of semiotic practices that both facili-

tate and constrain human meaning making (Geertz, 1973; Gone, Miller, & Rappaport, 1999). Culture is *social* (and often public) because such systems must be shared; there is no culture of one. Culture is *patterned* because such systems are organized and utilized systematically in order to be intelligible to others; they are not randomly recreated with each usage. Culture is *historically reproduced*, in that successive generations are socialized into using the intelligible systems of their communities (which is not to argue that culture is simply "transmitted" from one generation to the next, as innovations and modifications are constantly introduced both in the process of socialization and as subsequent generations adapt to novel circumstances). Finally, cultural practices are *symbolic*, in that they allow for the ascription and communication of meaning or "intelligibility" to others.

In other words, culture comprises shared patterns of activity, interaction, and interpretation. Perhaps the most salient example of culture is language, which serves as the primary semiotic system available to human beings for achieving mutual intelligibility, as well as the principal medium of intergenerational cultural reproduction. The study of mind and mentality within enculturated human communities makes it clear that cultural meanings and practices are just as central to realizing personhood as biological mechanisms or processes are. That is, human experience is crafted, constituted, or constructed from the complex and divergent ways in which culture and biology come together to render such experience possible. Thus, obviously, there is no culture without human biology—but, similarly, biology in the absence of culture is neither recognizable nor sustainable as human experience (Kirmayer, 2006; Wexler, 2006). Our point here is simply that, contrary to the evident commitments of the neo-Kraepelinians and the disciplinary traditions of psychiatry and psychology (which routinely refer to culture as rather superficially "shaping" or "influencing" putatively more basic biological processes),[3] there is no compelling reason to routinely privilege biology as more fundamental than culture to many of the constructs of interest within psychopathology.

One example of the reductionist bias toward psychological processes that are in fact co-constituted by both biology and culture occurs routinely in the psychological study of emotion, one of the most basic constituents of psychopathological experience. Most forms of psychopathology are accompanied by troubling emotions, and specific kinds of emotional experience provide the phenomenological basis for two of the most prevalent DSM diagnostic classes (at least as surveyed in the affluent West): the "mood" and "anxiety" disorders. As a result, the psychology of emotion figures prominently in the study of psychopathology.

The Dominant Approach to Emotion Research

Oatley and Jenkins (1992) traced the conceptual paradigms that have guided emotion research in the discipline back to Darwin (1872/1965) and James (1890). Whereas Darwin emphasized the biological and evolutionary significance of emotional processes and James emphasized the phenomenology of emotional experience, both writers conceptualized emotions as *primarily* intrinsic biological or physiological properties of the organism. The Darwinian tradition in particular inspired research by Ekman (1984) into the cross-cultural prevalence of emotion. Drawing on the presumed evolutionary significance of facial expression in the communication of internal emotional states to other members of one's species, Ekman discovered that respondents from many of the world's cultures expressed consistent associations of certain facial expressions with comparable emotion terminology, suggesting the universality of at least six basic or core emotions. For Ekman, the cultural and linguistic diversity encountered in these investigations was less interesting than the search for affective universals.

Cognitive investigations of emotional experience by psychologists have also tended to assume a universal biological core to emotion (Oatley & Jenkins, 1992). Building on the early idea of James that an emotion was the "feeling of the reaction to an event" (Oatley & Jenkins, 1992, p. 58), the neo-Jamesian tradition declared that "emotion was perception of a generalized arousal plus an attributional label" (p. 58). Although this idea represents a step beyond the view of emotion as fundamentally a biological pro-

cess, it suggests that a cognitive attributional label has been overlaid on the physiological core of emotion. Focusing on the cognitive mechanisms involved in emotional experience, contemporary psychology tends to emphasize the specificity and function of emotions, including their effects on attention and memory as well as their communicative roles in social interactions. These investigations have acknowledged that "the conditions that elicit an emotion distinguish it from other emotions" (Oatley & Jenkins, 1992, p. 60), and a growing body of work has examined the social determinants and consequences of emotion. Although these relatively recent developments in psychology seem to be conceptual moves in the right direction, there remains a conceptual bias toward viewing emotions as a set of biophysical and intrapsychic states. In this view, emotions are natural kinds, and culture is relegated to the role of configuring the situations that elicit emotions and shaping their outward expression.

But is culture really so peripheral to the psychology of emotional experience? In the past two decades, philosophers, cultural historians, cross-cultural psychologists, and anthropologists have trained critical attention on the dominant conceptualization of emotional experience and expression. Grounded in constructivist approaches to the study of self, personhood, and social relations, these scholars have proposed a reconceptualization of affect that transcends the Western notion of emotions as primary physiological processes with secondary cognitive, social, or cultural overlays. The result has been a new paradigm for emotion research that acknowledges biology, but that also gives serious attention to the cultural construction of experience (Abu-Lughod & Lutz, 1990; Griffiths, 1997; Gross, 2006; Harré, 1986; Kitayama & Markus, 1994; Leavitt, 1996; Lutz & White, 1986; Reddy, 2001; Rosaldo, 1984; Shweder, 1993; White, 1993).

The Constructivist Alternative for Emotion Research

The primary challenge facing the new paradigm for emotion research is overcoming the Cartesian dualism evident in most Western academic traditions (Leavitt, 1996) that gives rise to a familiar series of conceptual dichotomies (e.g., natural vs. cultural) that shape Western discourse. Several such dichotomies are evident in both scientific and Western folk discourse about emotions: mind versus body, cognition versus affect, thinking versus feeling, rational versus emotional, conscious versus unconscious, intentional versus unintentional, controlled versus uncontrolled, and so forth (Kirmayer, 1988; White, 1993). These conceptual oppositions are deeply ingrained in Western thinking and have resulted in "two-layer" theories (Lutz & White, 1986) or "dual-process" models (White, 1993) of emotion that conceptualize affect as "psychobiological processes that respond to cross-cultural environmental differences but retain a robust essence untouched by the social or cultural" (Abu-Lughod & Lutz, 1990, p. 2). Thus, with regard to the study of emotions, "any phenomenon acknowledged to be culturally variable (e.g., the language available for talking about emotion) is treated as epiphenomenal to the essence of emotion" (Lutz & White, 1986, p. 408).

Instead of replicating such dualisms, cross-cultural researchers with serious commitments to examining the individual as an embodied agent in a sociocultural context must transcend such thinking. Leavitt (1996) described an appropriate outcome with regard to the study of affect:

> We would have to see emotions as primarily neither [cultural] meanings nor [psychobiological] feelings, but as experiences learned and expressed in the body in social interactions though the mediation of systems of signs, verbal and nonverbal. We would have to see them as fundamentally social rather than simply as individual in nature; as generally expressed, rather than as generally ineffable; and as both cultural and situational. But we would equally recognize in theory what we all assume in our everyday lives: that emotions are *felt* in bodily experience, not just known or thought or appraised. (p. 526)

Although Leavitt was perhaps a bit too dismissive of the private, inchoate, and sometimes inexpressible qualities of emotions, his larger point is clear: The dominant characterization of emotions as fundamentally individual, interior, biological events must be counterbalanced with attention to their cultural, social, and expressive dimensions.

What concretely, then, does all of this imply for the study of emotional experience—and, by extension, to the study of psychopathology as well? First, as a research construct, emotions must be understood to include biological, psychological, linguistic, social, and cultural processes that are unified in the embodied person engaged in situated and meaningful action. Second, claims regarding the uniformity of emotional experience across cultures (at least in any nuanced sense) seem implausible. An affective experience that is substantively constituted by its semiotic context cannot possibly be universal (i.e., mean the same thing) across all cultural communities of the world (see Wierzbicka, 1999, for numerous examples). Finally, the meanings of emotional experience, as facilitated and constrained by linguistic practices in particular, are situated within wider conceptual webs of cultural meaning regarding personhood, social relations, spirituality, the moral order, and so on (Harré, 1986; Lutz & White, 1986; Shweder, 1993; White, 1993). Of particular interest here is the manner in which such local webs of meaning inform and construct emotional experience for the person. Thus a systematic exploration of local ethnopsychology (i.e., theories of mind, self, and personhood) must be central to studies of emotional experience and psychopathology across cultures.

An illustration of these issues is found in the work of anthropologist Theresa O'Nell (1996) on depression among the Salish Indians of the Flathead reservation in northwestern Montana. Similar to Kleinman (1986) in his investigations of Chinese neurasthenia, O'Nell discovered that depression on the Flathead Indian reservation was explicitly associated with community experiences of colonial conquest and historical oppression, as exacerbated by ongoing contention with European American racism. Most importantly, O'Nell determined that depressive-like experiences among the Salish were explicitly cast in relational terms (e.g., these were characterized by feelings of interpersonal loneliness rather than intrapsychic sadness). The relational orientation of this sociocentric society thus gave rise to three persistent states of being that shared symptoms of DSM major depression: feeling bereaved, feeling aggrieved, and feeling worthless. Of these, only the third condition was at all likely to lead to suicide, while the first was in fact esteemed as a mark of maturity among elderly Salish tribal members, who were seen to grieve appropriately for the many losses experienced by members of Flathead society over the previous century and more. The lesson here is that forms of psychopathology that are characterized by distressing or disordered emotional experience may be configured quite differently for individuals from societies that construe the person in more egocentric or individualistic terms and from those that are more sociocentric (Kirmayer, 2007b).

Implications for Cross-Cultural Psychopathology

Cross-cultural work on emotions has shown that most complex feelings are tied to specific developmental experiences and social scenarios, which depend in turn on social structure and cultural knowledge and practice. If culture thus has the depth and sweep to actively co-constitute the varieties of emotional experience around the world, then human emotions are best understood not as "natural kinds" but instead as "human kinds," born of an interaction between biological processes and cognitive and social construals (Griffiths, 2004; Hacking, 1995a, 1999; Hinton, 1999). This interactional, biosocial view points to a way to integrate our understanding of the embodied substrate of emotion with the complex social and cultural practices that give meaning and import to emotional experience as they unfold through development. Neo-Kraepelinian psychiatry—with its commitment to biological reductionism and the accompanying presumption that "real" psychiatric disorders are natural kinds—cannot do justice to this complex interaction.

DSM and the Problem of Cultural Imperialism

As we have already observed, the publication of DSM-III (APA, 1980) was a landmark historical, scientific, and political achievement, signaling the advent of neo-Kraepelinian psychiatry in the United States. Owing to standardized criterion sets with explicit application algorithms, modern versions of

DSM afford reliable psychiatric diagnosis, and thereby permit a cumulative science of psychopathology. Of course, construct validity for the hundreds of postulated disorders within DSM remains elusive; instead, psychopathologists employ DSM under the optimistic assumption that over time, accumulating evidence from research studies using standardized diagnostic criteria will enable them to "bootstrap" their way to diagnostic validity.

Nevertheless, DSM has come to dominate the ways in which mental health professionals in the United States and in many other countries classify and diagnose psychiatric illness—and, as a consequence, to suffuse the ways in which patients (and the broader public) make sense of their distress and dysfunction. That is, in everyday clinical practice, the *hypothetical* constructs classified within DSM take on a privileged ontological status in the lives of patients, professionals, and institutions through routine processes of reification. Indeed, it is through clinical praxis that the scientific and clinical conjectures codified in DSM become accepted as authorized knowledge and authoritative discourse. In actuality, then, DSM simultaneously serves two different purposes that are potentially at odds with one another: namely, as a provisional *scientific taxonomy* for facilitating empirical research on the one hand, and as an institutionalized *professional manual* for guiding clinical practice on the other (Gone, 2003b). The tensions between these functions (and epistemic stances) are greatly exacerbated in cross-cultural applications of DSM, especially those in which enduring asymmetries in cultural capital and political power lend themselves to the unwarranted hegemony of Western psychiatric discourse.

Psychiatric Services and Western Cultural Proselytization

Contemporary views of culture recognize that most individuals have access to multiple cultural systems, and that the "culture" of specific communities is actually made up of many competing and contesting streams or positions. Acknowledging the importance of cultural difference is not simply a matter of taking account of variations in developmental experiences, social contexts, and commitments. Cultures are unequally accorded or invested with power and authority. The power attached to specific cultural systems and communities arises from a specific history of domination and control that may continue to exert effects on ways of thinking long after the machinery of domination has been challenged or dismantled.

In psychiatric research concerned with the mental health status of historically oppressed ethnic/racial minority communities in the United States, for example, psychopathologists must recognize that the "culture" of the clinic is not the "culture" of the community. More specifically, the assumptions, assertions, aspirations, and attributions that mental health professionals routinely rely on are grounded in the categories and conventions of Western therapeutic discourse, including those contained within DSM. Such discourse has emerged historically from northern European and European American sensibilities regarding normative and disordered psychological, emotional, and behavioral functioning (Gaines, 1992). As a result, the therapeutic discourse that anchors mainstream clinical activity undertaken in many non-Western cultural contexts may diverge in substantial ways from local assumptions and expectations of wellness, health, and "the good life" (as we have already seen in the context of emotional experience and expression). Moreover, for much of the history of psychiatry, the profession has worked in cooperation or collusion with the powers of colonial domination (Bhugra & Littlewood, 2001; Jackson, 2005; Keller, 2007; McCulloch, 1995; Sadowsky, 1999). More specifically, the privileging of Western theories of psychopathology and therapeutic discourse has been associated with long-standing efforts by European Americans to express or achieve cultural dominance over other peoples through processes of colonization, and to maintain dominance through racialized hierarchies of power and authority.

This historical bid for European American cultural dominance frequently involved the explicit devaluation, disruption, and displacement of these alternate frames of reference, modes of representation, and modalities of experience. A small group of psychiatric thinkers and practitioners has challenged this collusion, rejecting the rac-

ist ideologies that rationalized colonial violence, and supporting the political struggles that have sought to transform or overthrow colonial regimes (Fanon, 1982). The result is an important literature that has examined the impact of colonial systems of racism and oppression on the identities, personalities, and psychological well-being of colonized subjects, as well as the possibilities for liberatory psychiatric practice (Vergès, 1996). This literature would benefit from contemporary reconsideration in light of the changing forms of structural violence (Gilroy, 2004). Nevertheless, despite these occasional (and politically marginalized) efforts, both cultural divergences and asymmetries in power render the provision of conventional psychiatric services to historically oppressed communities a politically suspect activity that may advance Western cultural proselytization in the guise of therapeutic knowledge and activity.[4]

A Postcolonial Discourse of Distress

We can illustrate the kinds of ideological dangers we have in mind with reference to two of the most prevalent forms of DSM psychopathology: alcohol dependence and major depression. In an ethnographic investigation on a northern Plains Indian reservation, Gone (2007, 2008c) identified a prototypical "discourse of distress" concerning problematic drinking and depression in contemporary Native American tribal life. According to one especially instructive respondent (pseudonymously named "Traveling Thunder"), these problems could be traced to disrupted ceremonial tradition in the context of historical dominance by European Americans. More specifically, Traveling Thunder identified four historical epochs in his characterization of the causes of pathological depression and drinking on the reservation. The first epoch was the era of "Paradise," a precolonial existence in which such pathologies were largely unknown, owing to the perfect harmony and balance wrought by community adherence to the strict observation of social custom and sacred ritual. The second was the era of "Conquest," or the colonial encounter in which the genocidal and assimilative activities of European Americans led to the annihilation of custom and ritual. The third epoch was the era of "Loss," in which the postcolonial effects of the annihilation of custom and ritual led to anomie, and in turn to substance abuse, depression, and sometimes suicide. Finally, the current epoch is the era of "Revitalization," in which the Creator has "pitied" the people enough to facilitate a communal reclamation of indigenous custom and ritual.

In one particularly illuminating moment during the interview, Gone (2007) asked Traveling Thunder to reflect on the conditions under which he would refer a distressed loved one to the mental health professionals at the local reservation clinic. His reply lacked any trace of ambivalence:

> That's kind of like taboo. You know, we don't do that. We never did do that. . . . If you look at the big picture, you look at your past, your history, where you come from . . . and you look at your future where the Whiteman's leading you, I guess you could make a choice. Where do I want to end up? And I guess a lot of people . . . want to end up looking good to the Whiteman. . . . Then it'd be a good thing to do: go [to the] white psychiatrists . . . in the [reservation clinic] and say, . . . "Go ahead and rid me of my history, my past, and brainwash me forever so I can be like a Whiteman." (p. 294)

Thus, for Traveling Thunder, the activity of "white psychiatrists" on the reservation was explicitly marked as an extension of the colonizing project, in which indigenous selfhood remains a site of neocolonial engagement and resistance. As an alternative, Traveling Thunder proposed the reclamation of indigenous selfhood through the reestablishment of ritual practice. Such practice serves to link the human self to other-than-human Persons[5] in the respectful offering of gifts and prayers in exchange for the compassionate outpouring of prosperity and blessings. In the process, alienation and anomie are simultaneously (but secondarily) resolved through the establishment of a robust cultural identity (Gone, 2006a, 2008b, in press-a).

A central feature of Traveling Thunder's discourse of distress was its reliance on observations, inferences, and insights drawn from the sociohistorical and spiritual levels of experience and analysis. From this perspective, mental health problems—including the anomie, demoralization, depression, substance abuse, and suicide found on the reservation—were understood as direct

consequences of the European American colonial encounter that disrupted ritual relationships and community responsibilities to powerful other-than-human Persons. It follows that the most effective remedy for pathological drinking and depression within the community would be a restoration and return to individual and collective ceremonial practice (Gone, 2007). In sum, this contemporary ethnopsychological discourse configures wellness (i.e., life lived "in a good way") quite differently from the "mental health" of psychiatry and the associated professions, and posits quite different etiologies for serious distress (Gone, in press-c). For Traveling Thunder, pathological drinking and depression were functions of culture, history, and identity, contrasting sharply with the reigning psychiatric emphasis on genetic predispositions, chemical imbalances in the brain, and other biologically reductionist explanations as fundamental to these disorders.

As we have already noted, the concepts, categories, principles and practices of neo-Kraepelinian psychiatry—including the codifications of DSM—remain cultural artifacts, the meanings and mechanisms of which emerge from and depend on their cultural intelligibility within a shared discursive frame. As a result, casually embracing DSM in one's cross-cultural professional activity risks irrelevance at best, or an often subtle (but sometimes overt) Western cultural proselytization in the guise of therapeutic progress at worst. Certainly the ideological hazards of this nearly invisible "West is best" cultural imperialism in postcolonial societies and contexts such as Traveling Thunder's reservation homeland remain worrisome and require serious consideration and redress.

Decolonizing Psychiatry

"Postcolonial" is a term that has been used to characterize the struggles for liberation undertaken by formerly colonized peoples as they assert their social, political, and cultural autonomy. Such struggles, however, have not eliminated structures of domination established during colonial eras or prevented the emergence of new strategies of exploitation rooted in national or ethnic interests. These structures and strategies have the effect of maintaining inequalities, with profound consequences for the quality of life of formerly colonized peoples in postcolonial societies. In addition, recent processes of globalization have facilitated shifts in strategies of domination toward systems of power structured by consumer capitalism and the interests of multinational corporations and their associated economic institutions. For this reason, the prefix "post-" in "postcolonial" probably warrants scare quotes to denote the fact that many oppressive features of colonization have not ended, but instead have mutated or gone underground, only to reemerge in powerful new forms. Indeed, the increasingly global influence of Western psychiatry—accompanied by its material and discursive power to undermine or displace local notions of self, personhood, identity, emotion, social relations, spirituality, distress, wellness, and healing around the world—would seem to require a great deal more ethical attention to the role of psychiatric services as vehicles to export specific cultural values, particularly those of secularism and especially individualism.

By virtue of their creation, utilization, and dissemination by psychiatrists, the psychopathological constructs classified within DSM are generally cast in terms that locate the "disorder" within an individual. This reflects a "causal attributional bias" that may result in blaming the person for his or her affliction. In a now-classic article, Caplan and Nelson (1973) criticized "the tendency to hold individuals responsible for their own problems" (p. 199)—first, by focusing on "person-centered" characteristics while downplaying or ignoring situationally relevant factors; and, second, by attributing causal significance to any person-centered variables found to be statistically associated with the social problem in question. Caplan and Nelson reviewed a sample of published articles indexed in *Psychological Abstracts* to demonstrate that in research with African Americans, psychologists invested "disproportionate amounts of time, funds, and energy in studies that lend themselves, directly or by implication, to interpreting the difficulties of black Americans in terms of personal shortcomings" (p. 204), rather than in terms of situational factors or systemic inequalities. They identified several social and political functions served by such construals of social problems, and concluded that "person-blame interpretations are in everyone's

interests except those subjected to analysis" (p. 210).

In light of these observations, let us return to the alternative presented by Traveling Thunder, who observed that the epidemic of distress in his reservation community appeared to have emerged hand in hand with the ravages of colonization. Traveling Thunder's account emphasized situational factors and systemic inequalities rather than "person-centered" biogenetic or intrapsychic factors. Accordingly, Traveling Thunder asserted that the community rather than the individual ought to be the focus of therapeutic attention and intervention, and that the problems faced by individuals and the community might best be characterized as an existential and spiritual crisis. Like the expressions of depression among the Salish recounted by O'Nell, and like the current appropriations of the term "historical trauma" among many other indigenous peoples and communities (Brave Heart & DeBruyn, 1998; Gone, 2008b, in press-a), Traveling Thunder's discourse embeds psychopathological experience in the larger meanings of *collective* experiences of longstanding European American subjugation. This focus on social and historical context as a way of characterizing individual suffering is in marked contrast to the dominant ideological commitments of neo-Kraepelinian psychiatry, in which mental disorders are presumed to be natural kinds that afflict individuals through presently unknown pathophysiological processes. To the extent that they employ this decontextualized view of psychiatric disorders, mental health services in the reservation context cannot help engaging in the sort of "person blaming" decried by Caplan and Nelson.

The basic remedy for this unfortunate state of affairs is to resituate individual and social suffering in its cultural and historical contexts. This has a political dimension, insisting on the importance of the interpretive frames and perspectives of the culturally diverse subjects of psychiatry theory. But the development of situated theory in psychopathology is not simply a matter of "political correctness." It requires a vibrant program of cross-cultural research on various forms of psychopathology—a program that seriously engages "emic" (local or emergent) frames of reference, in addition to the "etic" (external and imposed) models of psychology and psychiatry. Such research would not ignore conventional approaches to the investigation of psychopathology, but would recognize that the relationship between local and external models and frames of reference requires systematic study through open-ended empirical work that does not assume that either framework will provide all the answers. In some instances, the compelling validity of local understandings may directly challenge the constructs of DSM, demonstrating their inapplicability or irrelevance to local forms of suffering (i.e., Kleinman's [1988] "category fallacy"). In other cases, emic constructs may lead to models of wider applicability and so themselves become etic constructs. This systematic empirical project is based on the conviction that many forms of psychopathology (including some of the most popular and prevalent diagnoses) are "human kinds" best approached through careful investigation of the local, lived meanings of experience, rather than "natural kinds" that can be adequately characterized in terms of universal biological mechanisms and corresponding categories of experience.

Culture, Context, and Experience in Psychiatric Science and Clinical Practice

In line with the reflexive stance central to contemporary social studies of science, we have so far approached the importance of culture for psychiatric nosology through its impact on the nosological enterprise itself. This framework targets not the ethnocultural characteristics of patients per se, but instead addresses the cultural embedding of diagnostic theory and practice, especially as it pertains to everyday clinical concerns. The model discussed here is quite general and, in the context of preceding observations and insights, argues for professional recognition of the pervasive effects of culture and context on every aspect of the psychiatric enterprise.

The Uses of Psychiatric Nosology and the Impact of Diagnosis

Psychiatry covers a broad domain of human problems. Mental illness is not one thing,

but a congeries of heterogeneous problems—including forms of brain dysfunction, psychopathological processes that result from various forms of learning, problems that reside in interpersonal interaction, and problems that consist of incoordination or contradiction among these different levels of organization (Kirmayer & Young, 1999). These problems are related to one another by family resemblances, so that there is no common essence or single characteristic shared by every psychiatric disorder, except at a very high level of abstraction. Although, as we have argued, biological, psychological, and social factors contribute to all of these problems, the relative importance of causal and aggravating factors varies for each type of problem as well as for each individual, episode, and situation. As a result, no one solution to the structure and function of psychiatric nosology will work. In particular, neither genetics research nor neuroimaging will tell us what to include in a nosology unless we decide to redefine the domain of psychiatry narrowly in terms of these technologies (Robert, 2007; Robert & Plantikow, 2005).

The construction of a nosology and related diagnostic instruments and techniques reflects specific goals or purposes. Earlier, we have discussed the tensions between the use of psychiatric nosology as a provisional scientific classification of psychopathology and as a manual for professional practice. Diagnostic systems have additional uses in other domains, including the determination of health care policy and the regulation of other social institutions. The scope and content of a diagnostic system may have profound effects on the design and function of health care systems, including resource allocation and access to care. In the wider social context, diagnoses serve to position individuals by assigning them the sick role, and thus identifying the persons as legitimately distressed or disabled and deserving of help, compensation, or support. Diagnosis also has implicit functions. For the clinician, assigning a diagnostic label serves to name and contain the confusion and threat presented by the suffering patient (Kirmayer, 1994). For patients, a diagnostic label and its connotations are used to draw out the implications of an illness and, when the condition is chronic, to (re)construct aspects of personal identity. These implicit meanings of diagnosis may also have powerful social implications, conferring stigma or prompting other practices of exclusion.

A psychiatric nosology, then, is not simply a systematic ordering of categories found in nature, but constitutes a map and charter of a social world. Nosology provides a map, in that it marks off specific domains and establishes borders and boundaries whose crossing makes a difference to individuals' social status. Nosology also functions as a social charter because this act of mapping creates an "official" reality and authorizes the architects and users of the diagnostic system to exercise specific forms of social power. In the context of the clinic, diagnosis is part of constructing a problem list, identifying the issues that require some form of help or clinical attention. Clinical problem lists commonly go well beyond the specific entities of diseases or disorders to include social problems, interpersonal conflicts, and existential dilemmas—all of which figure in patients' suffering, and which may influence the appropriate intervention for specific disorders or may be primary foci of concern in their own right.

Clinical Epistemology and the Place of Culture in Psychopathology

Scientific research and clinical assessment involve different epistemological assumptions. Clinical knowledge is constrained by the temporal frame of the clinical encounter and its specific goals for problem identification and solution. The focus is on signs and symptoms, and on what can be identified through history taking, systematic interviewing and observation, physical examination, and laboratory tests. The aim is to use this information to infer the underlying disorder that accounts for a patient's distress and that can then be targeted for intervention. The implicit theory of medical semiotics views symptoms simply as more or less veridical reports of bodily events or physiological perturbations (Kirmayer, 1994). Although the mapping from pathophysiology to symptom may be many-to-one (nonspecific symptoms may result from many different forms of pathology) or one-to-many (a single pathology may have variable clinical manifestations), in practice medical semiotics commonly as-

sumes a one-to-one mapping or isomorphism from physiological disturbances to bodily experience and from bodily experience to symptom report. Hence symptoms are taken as indicators of underlying pathophysiological processes. Given the lack of independent biomarkers for psychiatric disorders, an assumption is also made that clusters of symptoms (syndromes) are sufficient to identify distinct forms of pathology. Furthermore, it is tacitly assumed that the diagnostic nosology identifies all the clinically significant forms of pathology that can occur. The accuracy and completeness of the nosological map are therefore matters of great importance for science, clinical care, and policy. Problems that fall outside the nosology are not accorded the same level of interest, status, or priority by researchers, clinicians, and policymakers. This makes the nosology an important regulator of psychiatric science and practice.

This is an especially important issue in cross-cultural work because of the epistemological problem identified by Kleinman (1988) as the "category fallacy." Efforts to apply a set of diagnostic categories developed in one cultural context in a different setting may obscure important cultural differences. Although it may be possible to identify people who fit the diagnostic criteria, this does not ensure the local validity of the category; nor does it rule out the possibility that individuals with related forms of suffering are not captured by the diagnostic criteria. Local categories of illness may yield better indicators of distress, and better predictors of prognosis and treatment outcome. Testing this possibility requires specific research methods (Canino, Lewis-Fernandez, & Bravo, 1997).

An additional epistemological problem arises from what Hacking has called "the looping effect of human kinds" (Brinkmann, 2005; Hacking, 1995a, 1999)—an elaboration on our prior consideration of "natural kinds" and "intentional categories." Hacking recognized intentional categories (or human kinds) as those that depend on specific ways of construing experience. In such instances, the very act of diagnosing a given pathology in an individual harbors the potential to alter that individual's experience of the pathology, as well as the subsequent scientific and professional construals of that individual's behavior. These ways of construing behavior circulate in the larger society, becoming social and cultural norms, models, and practices that alter other individuals' interpretations of their own experiences. Hence changes in cultural assumptions or cognitive models will lead to new conceptual categories that are reified and stabilized by recursive social processes of dissemination and enactment. The changing forms of "trauma" reviewed earlier, as well as the evolution of "hysteria," provide clear examples of this phenomenon (Hacking, 1995b, 1998).

Although we have previously employed Shweder's (1988) distinction between natural kinds and intentional categories (or human kinds), many psychiatric categories are best thought of as what Hacking terms "interactive kinds," in which there is a transaction between natural distinctions and culturally constructed concepts. Cognitive theory would suggest that panic disorder and major depression are two examples of a specific version of interaction that Hacking calls "biolooping," in which (culturally mediated) modes of construing experiences of the body and the self lead to physiological disturbances (Hinton & Hinton, 2002; Hinton, Hinton, Pham, Chau, & Tran, 2003). To the extent that these disturbances follow a biologically dictated final common pathway, the disorders may be viewed as ultimately independent of our construals, and hence as natural kinds (Cooper, 2004). For example, if there were a core syndrome of neurasthenia or depression involving a state of physiological depletion, we might fix on this aspect to define a category of pathology independently of how an individual arrives at that state (Kirmayer & Jarvis, 2005). However, there may be forms of psychopathology in which the culturally and cognitively mediated modes of construal are essential to defining the problem. In the case of "intentional" behavior, which is distinguished by the fact that the person can give reasons for their action (and that the reasons are causally implicated in the action), there is a loop that depends on the distinctively human capacity for self-awareness. For this type of problem, there is no way to define the pathology without characterizing the nature of the disturbances in self-awareness, self-representation, and self-control, which in turn depend on particular cultural con-

cepts of self and personhood, and on larger systems of values, social institutions, and discursive practices (Kirmayer, 2006).

None of these distinctions means that we must dispense with constructing categories, but we must recognize that the larger social contexts of psychiatry—including cultural notions of personhood and affliction—loop back at multiple levels into our nosology; into the process of clinical assessment and diagnosis; and into the vicious circles of attention, attribution, and behavior that constitute many forms of psychopathology (Kirmayer & Sartorius, 2007). Psychiatric nosologies, therefore, do not simply describe problems out there in the world, but actively contribute to the ways in which people construe and experience their distress. That is, as we have seen, psychiatric nosologies actively create culture even as they reflect cultural processes and practices.

Implications for Research

To the extent that social processes of meaning construction and positioning are central to the cause, course, and outcome of various forms of psychopathology, research must include systematic attention to the range of variables reflecting cultural variations in human experience. Given the marked heterogeneity within ethnocultural groups, this must go beyond mere comparisons of individuals on the basis of their ethnic identity, to examine the impact of specific knowledge, behaviors, or practices that can be linked to putative psychopathological processes. This type of research would decompose "culture" and "ethnicity" into explicit components or dimensions (e.g., specific practices associated with the body, concepts of personhood, explanations of affliction, techniques of healing) that can be studied in interaction with other biological, psychological, and social processes. However, a basic insight of anthropology is that the components of culture are not arbitrarily arranged, but constitute coherent systems (even if they contain tensions and contradictions), so that the interactions between different components must be studied to understand the tradeoffs that may occur for individuals following one or another illness trajectory.

Beyond this incorporation of culture as sets of interrelated components, "factors," or parameters that configure human biology, psychology, and the social contexts that govern behavior (whether pathological or adaptive), we have argued that the refinement of theory in psychopathology requires systematic attention to the social, cultural, and historical dimensions of human suffering and of the conceptual systems we devise to categorize, explain, and intervene. These deserve critical analysis not only for political reasons, since they have served as instruments of oppression or exclusion, but also because, in the nature of human experience, our conceptual categories shape our lives in ways that can give rise to new types of problems and solutions. Study of these "intentional kinds" and social looping effects requires different methods from those that currently dominate psychopathology research, including the critical and interpretive strategies of the social sciences, but also empirical studies of the social, economic, and political shaping of psychiatric knowledge and practice (Healy, 2004; Horwitz & Wakefield, 2007). This social analysis is not only a corrective to the tendency to promote specific models that serve special interests; it also opens a space for fresh thinking about the nature of psychopathology and well-being.

Implications for Clinical Practice

Although psychiatric diagnoses serve as a form of explanation, they differ in important ways from the biographical accounts common in personal narratives (McHugh & Slavney, 1988). Psychiatric nosologies contain generic information on postulated diseases and disorders. The act of diagnosis maps a patient's idiosyncratic story and clinical presentation onto a general set of categories. It does this by abstracting the essential characteristics of the patient's history and illness experience, paring away the irrelevant details, and seeing through the obscuring masks of style of narration and illness behavior to uncover the essence of a prototypical disorder. This, at least, is how disease categories and nosologies are constructed as systems of ideal types. Some concession to individual variability in illness manifestations occurs in the construction of polythetic categories, in which a case needs only a certain number of symptoms from a list to meet diagnostic criteria.

In contrast to this abstracting, decontextualizing, and essentializing process in the construction of disease categories, clinical explanation moves in the opposite direction. To convey a meaningful diagnosis to a patient and plan an appropriate clinical response, the clinician must particularize, qualify, and contextualize illness explanations. Often, however, clinicians simply present a generic story to patients modeled on the disease prototype. Unfamiliar symptoms or problems are reinterpreted to fit a specific prototype, or discounted and ignored as minor and irrelevant. Insofar as a patient's experience does not fit the template, the discrepancies are viewed as irrelevant or the patient is viewed as a poor historian, oblivious to or misinterpreting the true nature of his or her condition (Kirmayer, 1988, 1994). This stripping down of illness experience to fit the diagnostic paradigm is justified on the basis of the notion that diagnostic entities have essential biological characteristics, and that what is crucial about the patient's condition can be typified by these core features. However, this does not address the basic mandate of medicine. People bring symptoms and predicaments to their doctors, not just diseases or disorders. These predicaments may contribute to the cause, course, and outcome of specific disorders. Because these predicaments are socially constituted, they will differ across social and cultural contexts, giving rise to potentially important differences in the nature of psychopathology.

Strategies for including social and cultural context in clinical assessment of psychopathology include the cultural formulation presented in an appendix to DSM-IV-TR (APA, 2000). This was introduced by a working group of psychiatrists, psychologists, and anthropologists, to provide a minimal list of the sorts of contextual factors to be considered in assessing psychopathology (Mezzich et al., 1999). The list includes identity, illness explanations, functioning, family or social supports, and the relationship with the clinician. Since its introduction, many case studies using the cultural formulation have been published, but there has been no systematic assessment of its utility. Given all of the arguments we have adduced above, it would seem that something akin to the cultural formulation is crucial to provide balance to the decontextualized view of problems inherent in DSM. Clinical experiences with cultural consultation clearly demonstrate the potential of the cultural formulation to identify errors in diagnosis and produce more comprehensive and culturally appropriate assessment and treatment plans (Kirmayer, Groleau, Guzder, Blake, & Jarvis, 2003). Much further work is needed to elaborate the cultural formulation, evaluate its utility, and give it more prominence as a way to foster clinical thinking that moves from abstract category to lived reality.

Conclusion

In this chapter, we have considered what is at stake in the assimilation of local discourses of distress into the increasingly global discourse of neo-Kraepelinian psychiatry—with its overt construal of various forms of psychopathology as "natural kinds" arising from distinctive, underlying pathophysiologies. We have outlined an alternative perspective that gives due weight to culture in the study of psychopathological experience. This view centers on the importance of meaningful human predicaments as a way to understand the interaction of biological, psychological, and social processes in the emergence of distinct (though not discrete) forms of psychopathology—forms that depend to varying degrees on social context for their shape, content, and "natural history." In this view, the diagnostic entities found in psychiatric nosologies may not reflect natural kinds (occurring in nature independently of our cognitive and cultural construals), but are the outcomes of social-interactional and historical processes that include our culturally mediated ways of understanding and interpreting human suffering.

For the most part, culture functions as a taken-for-granted background that sustains our common sense and tacit knowledge of the social world, as well as our clinical models, institutions, and practices. We recognize culture only at the margins, in the encounter with those we view as different or "other." Confronting our own cultural assumptions through encounters with others has been commonplace throughout human history, but most often cultural diversity has been subordinated to a single set of categories, concepts, and values imposed by dominant

groups, which work to devalue and disqualify alternative frameworks for experience.

Psychiatry itself has practiced this form of conceptual imperialism, and challenges to this hegemonic view are few and far between. In recent years, however, migration and telecommunications have brought new levels of cultural diversity into clinical settings in many parts of the world. Culture then presents itself as a daily problem of recognizing and addressing diversity in the clinical application of psychiatric nosology (Kirmayer & Minas, 2000). This diversity cannot be addressed with theories of psychopathology and a psychiatric nosology based on research conducted in only one or a few cultural contexts (Alarcón et al., 2002). Enlarging the study of psychopathology by emphasizing the contextual shaping of psychiatric problems holds the prospect of generating a more accurate view of the sources of suffering and the mechanisms of psychopathology. Attention to culture, then, is not only a matter of serious ethical, political, and pragmatic issues in the delivery of mental health care, but a basic requirement for a science of psychopathology that seeks to understand our nature as cultural beings. Human biology is *cultural* biology. The wisdom—we should say the necessity—of attending to culture in the development of psychopathological theory and in the preparation of future nosologies therefore emerges on the grounds of both scientific and political aspirations.

Acknowledgment

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Notes

1. We use scare quotes here to acknowledge the fact that the "phenomenology" of DSM-III (APA, 1980) and DSM-IV (APA, 1994) gives scant recognition to the realm of inner experience explored by several generations of phenomenologically oriented philosophers and psychologists working within a Continental tradition. Instead, "phenomenology" in the DSM system means discrete symptoms, signs, and behaviors that can be reliably measured by an external observer.
2. In fact, the distinction between natural and intentional kinds (like that between positivist and constructivist epistemologies) is overstated, and the examples themselves point to the difficulty of making a sharp contrast. Ian Hacking (1999) has described the wide range of uses of the notion of social construction, and has also provided some compelling examples of the social construction of psychiatric disorders (Hacking, 1995b, 1998). However, most examples of intentional categories in the area of psychiatry are what Hacking has called "interactive kinds," built out of an interaction between more or less obdurate features of the natural world (including our own physiology and psychology) and socially mediated responses.
3. Historically, in the study of culture and psychopathology, this has been framed as a contrast between "pathogenesis," usually assumed to involve biological processes or physical interactions with the environment, and "pathoplasticity," the cultural shaping of the expressions of more basic pathogenic processes.
4. One of us has argued this claim in more detail in a series of papers (see Gone, 2003a, 2004a, 2004b, 2006b, 2008a, 2009, in press-b; Gone & Alcántara, 2007).
5. In the traditions of many indigenous peoples—particularly those who were hunters—animals and other "natural" beings were seen to possess some of the same qualities of human personhood (e.g., autonomy, intentionality, and so forth) and hence are best termed "other-than-human Persons." The capital P serves to convey respect for their often sacred status.

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