on psychosomatic wards. This is hardly a Laingian anti-psychiatry enterprise.

Professor Leff fails to do justice to the important conceptual and practical innovations offered by Kleinman (1988). These include the systematic creation of an ethnography of each patient's experience of illness and his or her "explanatory model"; a recognition of the culture-bound nature of the idioms of distress used by laymen to indicate dysphoria; and a heightened awareness of psychiatry's own cultural origins and tacit assumptions and its tendency to systematically minimise cultural differences in the symptoms and interpretation of mental illness.

MAURICE LIPSEDGE

Guy's Hospital
St Thomas Street
London SE1 9RT

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SIR: Leff (*Journal*, March 1990, **156**, 305–307) gives the wrong impression about what anthropologically-orientated studies in psychiatry are all about.

Professor Leff uses the example of smallpox to criticise an epistemological approach to psychiatry, which he appropriately associates with anthropological works on psychiatry, yet inappropriately implies is a continuation of nihilistic anti-psychiatry. For Professor Leff, vaccination, which Jenner developed from 18th-century English folk beliefs, was successful in eradicating smallpox; Yoruba and Hindu ethnotheories about this disease, however, were not effective and therefore, unlike biomedical categories, did not become dominant. Although his intended meaning is unclear here, especially since he qualifies his argument with examples where success is greater for indigenous therapies of Third World societies, Professor Leff seems to imply a utilitarian justification of psychiatric categories.

This is a strange conclusion to draw from the smallpox case for several reasons. The World Health Organization's (WHO's) eradication campaign was a logistic, administrative and political triumph which drew upon knowledge of local cultures and the WHO's own institutional culture to overcome obstacles, some of which derived from contemporary public health policies. Furthermore, as Marglin (1988) indicates, the eradication of smallpox in the Indian subcontinent had some ironic twists. The traditional Indian practice of variolation, which had a certain measure of efficacy, was outlawed by the British government in India in 1865, and this both worsened the public health situation and contributed to the colonial policy of fostering Indian dependence in the sphere of health. Later on during British rule, the popular resistance to the compulsory vaccinations introduced in some provinces was a surrogate for more widespread political resistance and led to a worsening of the smallpox problem. Moreover, the forced vaccinations in the 1960s and 1970s, which ultimately eradicated smallpox, produced such resistance that its after-effects still reverberate, causing obstacles to public health programs. It was not biomedical categories, then, but cultural values and political interests which fostered both the successes and negative consequences of smallpox eradication campaigns.

The beliefs, rituals and community activities in honour of Sitala – the smallpox goddess – are associated with "their ability to regenerate the community, to create or re-create social consequences" (Marglin, 1988, p. 7) and are part of a Hindu view of health as the *result* of the experience of illness and death, and not as their opposite or enemy. Seen from the perspective of how Indian culture responds to near-death experiences of the aged and the chronically ill, the Hindu conception may be more successful, at least with respect to these experiences, than its biomedical counterpart.

The anthropological approach to psychiatry begins with cultural epistemology because this is useful to understand the indigenous or lay beliefs about illness and how these constrain treatment decisions. Anthropological investigations also show how a health problem is constructed as a technical/professional problem through the application of diagnostic categories and clinical assessment methodologies, and how this creates an 'object' of psychiatric practice. Biomedical categories strip away the illness experience, including the moral condition of suffering, to get at disease pathology. When that reduction is successful, as is the case with many treatable acute infectious diseases, it is an example of a remarkably useful cultural bias. When it is relatively unsuccessful, which is often the case in chronic medical and psychiatric conditions, the outcome is a form of dehumanised care *and* also an impoverished scientific epistemology for medicine/psychiatry.

In my book (Kleinman, 1988), I tried to show how an epistemological approach to psychiatric practice can be a useful method for uncovering and remedying serious biases in our taxonomies, value hierarchies and treatment practices that limit our discipline's utility in developed *and* developing societies. The

role of anthropology itself should be to clarify when the 'culture' of psychiatry itself becomes an obstacle to effective and humane treatment and prevention programs. Thereby, anthropologically-oriented psychiatry can contribute toward a kind of emancipatory self-reflection on how to keep our rational technical devices from becoming an iron-cage of reified (and as in much of DSM–III–R, commoditised) classifications whose utility is much less powerful and whose 'object' is all too readily dehumanised.

Cultural epistemology offers a needed complement to epidemiological, clinical and psychometric approaches to cross-cultural comparisons, and, since a knowledge of anthropology is as important in cross-cultural psychiatry as an understanding of, for example, neuroscience, Littlewood (*Journal*, March 1990, **156**, 308–327) should be praised for his anthropological contribution on how cultural meanings affect mental illness and psychiatry.

ARTHUR KLEINMAN

Department of Anthropology
Harvard University
William James Hall
Cambridge, Massachusetts 02138

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SIR: In my editorial (*Journal*, March 1990, **156**, 305–307) I did not intend to slight the valuable and innovative achievements of the 'new cross-cultural psychiatry' which Littlewood (*Journal*, March 1990, **156**, 308–327) detailed in his extensive review. Rather than underlining the points made in the review, I focused on the issue of the validity of psychiatric disease categories, which the new approach has brought into question. On reading Professor Kleinman's letter, I began to wonder whether I had set up Dr Littlewood as a straw man. However, behind this possibly spurious target stand solid ranks of critics, both within and outside the profession, who have seized as ammunition the notion that psychiatric categories are cultural constructions with no validity outside the realm of biomedicine.

The point I was attempting to illustrate with the example of smallpox eradication has been largely misinterpreted by Professor Kleinman and Drs Bracken & Giller. My argument does not rest on the overall impact on the health of a society, vitally important though that is. I maintain that the response of a condition to a remedy that is postulated to ameliorate or cure that condition and no other constitutes a validation of the disease category. If the same condition shows the same responsiveness across cultures, then that is evidence for the cross-cultural validity of the disease category in question. In short, I do support a 'utilitarian justification' of disease categories, including those constructed within psychiatry.

If this criterion for validity were confined to Western biomedicine, then we would be trapped within a tautology from which escape was impossible. However, I agree with Dr Haldipur that this approach is not exclusive to Western biomedicine. There is no doubt that traditional healers have discovered specific remedies for conditions that biomedicine recognises as diseases categories (e.g. quinine for malaria, Rauwolfia for psychoses). It is inconceivable that they could have established this link between condition and remedy without applying the principle of utility, and using it to select the patterns of presentation that were responsive. For healers and clients the acid test of a remedy is its effectiveness as a cure. As Waxler (1977) writes from her experience in Sri Lanka, "No family lingers long with any treatment person; one or two visits, one or two bottles of medicine are enough to convince them that the treatment cures or does not cure. If it is ineffective they move on; if it is effective the patient is 'cured' and needs no more".

It is here, I believe, that the doctor and the anthropologist face an ideological divide. As Kleinman affirms, an anthropologist is concerned with the value to society of rituals which "regenerate the community", even though they may be totally ineffective in helping the sick individual. However, the doctor's prime duty and responsibility is to that individual, even if she or he takes preventive measures at a societal level (e.g. by ensuring a supply of clean water). The doctor should be sensitive to cultural values when instituting preventive or curative measures, such as vaccination, but in contrast to the anthropologist, his or her paramount aim is to alleviate suffering. The construction of hypothetical disease entities based on a 'notion of pathology' is an essential stage in achieving this aim, a principle recognised by Western doctors and traditional healers alike.

J. LEFF

MRC Social and Community Psychiatry Unit
Institute of Psychiatry
De Crespigny Park
London SE5 8AF

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