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

References

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

MARGLIN F. A. (1988) *Smallpox in Two Systems of Knowledge*. Helsinki: UNU/WIDER Working Paper.

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

Reference

WAXLER, N. E. (1977) Is mental illness cured in traditional societies? A theoretical analysis. *Culture, Medicine and Psychiatry*, **1**, 233–253.

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