ABSTRACT. Cultural explanations of psychopathology in the West have rarely employed models derived by anthropologists for small-scale non-literate communities. Some general features of those ritual patterns usually classed as 'culture-bound syndromes' are applicable to Western neurosis. Such reactions articulate both personal predicament and public concerns, usually core structural oppositions between age groups or the sexes. They gain their power by relying on certain unquestionable assumptions which, although beyond everyday jural relationships, articulate such relationships. In the case of Western reactions, such 'mystical sanction' is provided by biomedicine. Theoretical paradigms emphasize either the individual pragmatic or expressive aspects, or social homeostasis.

INTRODUCTION

Psychiatric research is carried out principally in the comparatively homogeneous culture of urban industrialized societies. Psychopathology in the West thus tends to be regarded as if it were culture-free. Murphy (1977) correctly emphasizes that "the time is overdue when the relationship between cultural background and psychopathology should be more formally examined, and when we should cease thinking that our behavioral expectations are all 'neutral', not requiring re-examination". As Gaines (1982: 167) points out, although "the conceptual basis of Western psychiatric theory and practice are often assumed a priori to be culturally neutral [and] scientific", we can study Western psychiatry in the same way as we study a traditional theory of disease, "one no less constructed, informed and communicated than another". We shall argue in this paper that certain contemporary biomedical conceptualizations and their associated patterns of social action are closely tied to implicit cultural and political assumptions, particularly those concerning sex roles and notions of personal identity and attribution: conceptualization, therapy and the illness itself are articulated by a shared set of values. Whilst the notion that biomedicine is fundamentally different from other disease theories is being abandoned, there remains an assumption that Western science is too pluralistic to submit to the type of symbolic analysis which has proved so fruitful in the study of small scale communities. However, in this paper, in an attempt to minimize the reduction of our subject, which includes biomedical concepts, to such concepts themselves, and to achieve a greater degree of 'universality', we shall employ a model derived from ethnographic interpretation of non-Western patterns of 'psychopathology'.

While biomedical and traditional therapies have frequently been compared, the points of similarity have either been predicated upon the presumed universality of the physiological or psychodynamic mechanisms of Western therapy or upon 'non-specific' aspects of the therapist/client relationship (Janet 1925; Frank 1961; Kiev 1964; Torrey 1972; Sargant 1973; Prince 1976). The direct mapping of Western categories onto traditional systems has not been attempted because of the highly salient cultural contextuality of the latter as they appear to Western professionals (which has not prevented them from conducting the reverse procedure, mapping traditional categories onto Western systems, still the characteristic operation in 'transcultural psychiatry'). To attempt to identify traditional non-Western patterns in a Western population demands more than claims based on superficial phenomenological similarities that koró or amok occur in the West (see the examples cited in Littlewood and Lipsedge 1985; Simons and Hughes 1985); it requires the application to the West of the sociological models developed for small-scale communities. To the extent that such models are derived from within the Western academic tradition they remain culture-bound but at a higher degree of universality than explanations which themselves form part of the clinical construction of the reactions.

This paper examines certain relatively discrete reactions which appear, historically and geographically, to be specific to industrialized cultures, especially to the United States and Britain. While culture-specific reactions may of course have a distinct biological component (kuru, amphetamine psychosis), the term 'culture-bound syndrome' as found in small-scale communities has usually been taken to refer to: (i) local patterns of time-limited behavior, specific to a particular culture, which, whilst regarded as undesirable, are recognized as discrete by informants and observers alike; (ii) few instances of which have a biological cause; and (iii) in which the individual is not held to be aware or responsible in the everyday sense; (iv) the behavior usually has a 'dramatic' quality (Littlewood and Lipsedge 1985).

SYMBOLS AS SYMPTOMS

Such reactions frequently articulate personal predicament but they also represent public concerns, usually core structural oppositions between age groups or the sexes. They have a shared meaning as public and dramatic representations in an individual whose personal situation demonstrates these oppositions, and they thus occur in certain well-defined situations. At the same time they have a personal expressive meaning for the