What is culture-bound about illness: the ideas people subscribe to about the way illnesses behave or the way in which signs and symptoms actually occur and/or cluster together? Confusion between these two levels of discourse creates arguments about nosology and culture. Dr. Prince and Tcheng-Laroche propose a solution; let us focus on describing constellations of signs and symptoms and use these descriptions as the bases for psychiatric nomenclature. The authors argue that the DSM-III, a syndrome-based classification of diseases, comes close to being a truly international system; with slight modifications, a place can be found within DSM-III for many so-called culture-bound syndromes (CBS), even such exotic specimens as taijin-kyofu-sho. For other syndromes, which will be found not to fit, and which conform to certain inclusion and exclusion rules advocated by the two authors, new categories — culture-bound syndromes — can be created.

One intent of the paper seems to be to make DSM-III even more comprehensive than it currently is and, in those instances where conditions will be found which do not fit the DSM-III, to set out clear guidelines by which they may be defined as culture-bound syndromes. For this reviewer, Prince and Tcheng-Laroche's provocative paper raises two questions: Can and will most conditions "fit" the DSM-III format? Is the approach to unclassifiable illnesses a useful one?

CAN MOST CONDITIONS FIT DSM-III OR SOMETHING LIKE IT?

Prince and Tcheng-Laroche advance the premise that the closer one can come to achieving a nosology which cuts through the obscuring layers of cultural hermeneutics of illness to the bedrock of observable and recurring patternings of signs and symptoms, the greater the likelihood of scientific and clinical advance. Given our current scientific knowledge, this is a reasonable goal. However, despite Prince and Tcheng-Laroche's evident satisfaction with it, DSM-III is still far from being such a nomenclature.

To begin with, the constellations of criteria which make up DSM-III diagnoses are an amalgam of observation and inference. To the extent that inference enters into a system, culture will play a large role in determining how things are classified. The very notion of how and which symptoms and signs cluster together is, for the most part, not based on empirical
demonstrations from nature, but rather on beliefs shared by clinicians trained mainly within a Euro-American tradition. The DSM-III does not escape considerations of etiology; at an implicit level, at least, assumptions about causal chains in illness production determine such features in the system as decision rules regarding diagnostic hierarchies. It is after all, an assumption — one now being called into question — that depression is more “basic” than panic. This assumption, apparently shared by the framers of DSM-III, dictates the rule that when the two conditions occur together, panic should be subsumed under depression.

The role of inference in DSM-III has not been systematically made explicit. Many of its proponents might even deny that inference plays a role in this system. Prince and Tcheng-Laroche's insistence that observation, and not inference, underlie DSM-III categories leads them to what are at best incomplete formulations. For example, the authors seem ambivalent about what to do with \textit{taijin-kyofu-sho} (TKS). They state that TKS “can probably be considered a culture-bound syndrome” but then go on to suggest that it could probably be subsumed under “social phobia” if that DSM-III category were slightly modified. TKS consists of fear of giving offence or of making others uncomfortable either by speaking one’s thoughts aloud, by blushing, by body odor, or by the nature and intensity of one’s gaze. TKS and social phobia are constructs at a different level than, for example, “somatization disorder,” another DSM-III category. In the latter case, respondents who report bodily symptoms in excess of a predetermined cut-off point are considered to have the disorder. Thus, this diagnosis calls for little inference; it is simply a description of someone who complains of a great number of (clearly defined) somatic symptoms. TKS, on the other hand, which ranges from fear of thinking aloud to fear that one has a bad odor emanating from the genitals is more than a description. The glue which holds the TKS together is a construct — fear of giving offence. The mode by which the offence may be committed is considered secondary.

In a similar vein, the authors propose lumping together “neurasthenia,” a commonly observed condition in China, \textit{hwa-byung} complained of by Korean women and “brainfag” — a condition first reported by Prince among students in Nigeria. Despite the fact that in each of the different cultures different bodily sensations are emphasized, Prince and Tcheng-Laroche suggest that these are equivalent conditions whose underlying feature is a multiplicity of somatic complaints. They can all therefore qualify for a diagnosis of somatization disorder. Even if, in a purportedly descriptive system, one could accept the concept of symptom equivalence, there remains the troubling feature that a cardinal characteristic of