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COMMENTARY

Idioms of Distress Revisited

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I am pleased to have this opportunity to offer some reflections on what I have foreseen as an idioms-of-distress research agendum, and some thoughts on what an idioms-of-distress assessment adds to anthropological research on human suffering and culturally informed therapy facilitation in clinical settings. The term *idioms of distress* has now been in circulation for 30 years and has clearly taken on a life of its own. It was used in DSM IV and is likely to be considered for use in DSM V. A point of discussion in psychiatry at the moment is whether idioms of distress and "culture syndromes" are redundant terms or whether they refer to different phenomena.[1] I weigh in on this issue as well as address two critiques of the way the term idioms of distress has been conceptualized by some scholars. I suggest that a distinction among idioms of distress, cultural idioms of distress and cultural syndromes is warranted. And I suggest that the two critiques of idioms of distress reviewed are necessary correctives, returning us to the original intent of an idioms-of-distress agenda. Finally, I highlight a few of the unique contributions made by papers in this issue that push an idioms-of-distress assessment in new and productive directions.

In 1977, I wrote a pair of papers laying out an idioms-of-distress research agenda and calling attention to the role practitioners (from diagnosticians to diviners) play in framing experiences and expressions of distress in ways that Obeyesekere (1985, 1990) later came to refer to as the work of culture.[2] My papers were published a few

[1] One would hope that the term *cultural bound syndrome* currently used in DSM IV will, at the very least, be replaced by "cultural syndrome." Like many anthropologists, I have found the term cultural bound syndrome to be problematic for reasons summarized by anthropologists critiquing its inclusion in DSM IV (e.g., Hahn 1995; Hughes 1998; Kleinman 1997).

[2] The "work of culture" (Hollan 1994; Obeyesekere 1985, 1990) refers to the process whereby distressful states, perceived risk and motives, negative affects and sensations are transformed into

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years later (Nichter 1981a, b), while I was completing a postdoctorate at the Department of Psychiatry at the University of Hawaii and working as a therapy facilitator on the wards with patients (Nichter et al. 1985). My work with patients convinced me that the idioms of distress agenda was well worth pursuing not only in South Asia, but in community and clinical settings in the United States—and not just with "cultural others," but as a routine part of all patient assessment. I saw firsthand and on a daily basis how being attentive to idioms of distress led me to examine more closely interpersonal, social, political, economic and spiritual sources of distress, to appreciate tacit communication and to pay attention to cultural dimensions of illness experiences as well as responses to therapeutic interventions, from nosology to treatment to sick and risk role identities.[3] Recognizing idioms of distress helped me to establish rapport and build the type of empathic connection that comes from being co-present, engaging in a "somatic mode of attention" (Csordas 1993), "working within the metaphor" (Kirmayer 1993) and paying close attention to metacommunication (Bateson 1972; Wilmot 1980).[4] An idioms of distress assessment (not just a reductionistic "cultural assessment" originally requested of me by my supervisors on the ward) better enabled me to offer useful insights to psychiatrist colleagues in the process of conducting differential diagnosis (a work of culture) and to provide socially and culturally informed suggestions about care management. The latter involved an assessment of patients' social relational and economic, as well as "cultural," context and adaptive/maladaptive strategies for coping within these nested contexts. In sum, it was both ongoing ethnographic fieldwork on healing in South Asia and my experiences on the psychiatric wards in Hawaii (and later in Arizona) that led me to argue for an ethnomedical approach to the study of all systems of disease nosology and treatment (Nichter 1992)[5] and a transactional approach to the study of how distress is experienced and expressed by patients as well as interpreted by family members and practitioners.[6] I came to a realization aptly captured by Kirmayer (1989, p. 336):

> Diagnostic and treatment systems do not develop independently of the cultural matrix that shapes the experience and expression of distress. Consequently we

Footnote 2 continued
publicly accepted sets of meanings and symbols that can be manipulated or dealt with in some culturally salient manner. Importantly, Obeyesekere notes that "where subjective experience is often articulated through the medium of cultural symbols, cultural symbols are only ever imbued with significance once they are internalized and integrated into the context of an individual's emotional and motivational concerns" (see Throop 2003, p. 112).

[3] See Hinton et al. (2010) for a detailed description of the clinical utility afforded by an assessment of a sufferer's idioms of distress.

[4] Metacommunication refers to anything that contextualizes or frames a message such that it assists the participants to understand the communication event (Wilmot 1980, p. 64).

[5] Stating that biomedicine or the discipline of psychiatry is ethnomedical does not devalue it as an evidence-based scientific endeavor or privilege inquiry into cultural relativity above universal human processes. Use of the term draws attention to both the production of knowledge in cultural and historical contexts and the "action in the interaction" between culture and biology. See Kirmayer (2006) on the contribution of "cultural biology" to the new cross-cultural psychiatry.

[6] A transactional assessment of communication views it as a negotiation of meaning between parties responding to their environment and each other.

expect to find a measure of fit between local forms of distress and the methods of diagnosis and treatment.

Why "Idioms of Distress"?

At the time that I wrote "Idioms of Distress" (Nichter 1981b), I was concerned by the rather static way in which culture and indigenous medical traditions were being represented in ethnomedical studies, as distinct from culture being seen as a project in the making subject to local, regional and global influences. I also felt that anthropologists and transcultural psychiatrists were paying far too much attention to the "whatness" of particular cultural modes of expressing distress (possession states, witchcraft, "cultural bound syndromes" and so on) and too little attention to "Why this?" questions that might shed light on why particular individuals and groups embrace alternative means of expressing distress at specific points in time (see also Crandon 1983). I argued for an assessment of the range of possible ways in which different members of a population might express or enact various types, levels and intensities of distress, and the circumstantial factors favoring/disfavoring one culturally salient means of expression over another. I reasoned that it was necessary, but not sufficient, to investigate the semantic meaning of "cultural syndromes" (Good 1977) and what later came to be called the cultural epidemiology of cultural syndromes (the distribution of self-reported experiences of cultural syndromes and those risk/protective factors associated with their occurrence in a population).[7] My ethnographic fieldwork led me to see the importance of focusing on the pragmatics[8] and micropolitics of articulating distress in particular ways, and reasons why various stakeholders are invested in interpreting polysemious experiences of distress in a particular manner.[9] I came to recognize the social ramifications of expressing and interpreting distress in specific ways, not just

[7] I refer here to early studies such as those carried out by O'Nell and Selby (1968) and Rubel et al. (1985). More sophisticated cultural epidemiological studies also attend to "how" questions: how the afflicted and concerned others come to recognize, define and treat a condition (see, e.g., Kohrt et al. 2004).

[8] I use the term pragmatics in two distinct ways. The first indexes Charles Morris's (1971) juxtaposition of the terms *semantic*s and *pragmatics*. While semantics refers to the study of the signification of verbal and nonverbal signs, pragmatics refers to the study of the origins, uses and effects of signs. Morris defines a sign as any preparatory stimulus that produces a disposition in the interpreter of the sign to respond to something that is not at the moment a stimulus. Second, I use the term pragmatics to refer to a consideration of how a given context can have an influence on the meaning (and inferred meaning) of messages intentionally and unintentionally being communicated. Pragmatics in psychiatry is most closely associated with the Palo Alto school and the work of such researchers as Bateson, Watzlawick, Beavin and Jackson (see, e.g., Watzlawick et al. 1967). I was exposed to this school of relational communication theorists during my postdoctoral training in psychiatry.

[9] Following Nerlich and Clarke (2001), I think it is important to acknowledge that just as people who engage in conversations do not always strive for relevance, or intend words to have particular meaning, calling attention to a generalized state of distress may involve "purposive ambiguity" that serves subtle and emergent ends. On this point, see Mimi Nichter's (2000) writing on "fat talk." Speech actors also produce meaning in contexts of divination and diagnosis without intention other than recognition of distress and an overture being made for engagement (Du Bois 1993).

for the person suffering, but for his or her household, in keeping with such factors as moral identity, costs of treatment and so on. My research also led me to see just how crucial it was to consider the response or lack of response (itself a response) of significant others (e.g., household members, practitioners) to an individual's display of distress, and the manner in which feedback (or lack thereof) influenced the experience and expression of distress in a recursive fashion. Only when alternatives and feedback are considered, I argued, can one assess the extent to which the behavior of a particular person or group is adaptive (effective in some meaningful way) or maladaptive (problem-maintaining or -escalating) in context. Only then can one begin to understand shifts in (or the combination of) idioms of distress that occur over time.

I took it for granted that the social field in which idioms of distress occur is dynamic and subject to a great many factors, ranging from personal propensities[10] and household predispositions, to particular idioms of distress, to changes in the micropolitics of identity management in local contexts and the macropolitics of social dissatisfaction, insecurity, structural violence and so on. I observed how emerging disease outbreaks (and reports of outbreaks) provide an opportunity both for individual anxiety to be expressed as new idioms of subjective risk (e.g., pseudo-AIDS in India; see Jacob et al. 1989; Chandra and Ravi 1995) and as an outlet for the expression of collective anxiety. The latter often takes the form of metacommentary on social injustice and failure of the government to protect the body politic (Nichter 2008a, b) or is associated with such forms of discrimination as racism (e.g., Briggs 2005; Briggs and Mantini Briggs 2003). Like Kirmayer (1994), I became intrigued "not only by the natural metaphoricity of symptoms that might be used to convey distress somatically, but the perfomativity and improvisation of expression that occurs upon changing social and cultural stages." I have observed with great interest as new spaces for the articulation of distress opened up as a result of diagnostic categories de jour (such as ADHD and PTSD) becoming social facts and taking on a social life of their own in popular health sectors. And I have watched with equal interest as expert bodies struggled to be gatekeepers for these new cultural syndromes while, at the same time, bracket creep (category expansion and intrusion) was occurring.

I found Raymond Williams's (1977) writing on ideology to be insightful in its understanding of shifts in the popularity of idioms of distress given culture as a work in progress. According to Williams, we always live with ideologies of the past, the present and those emerging on the horizon of a possible future. We likewise live with idioms of distress from the past, which may take on new or hybrid forms and maintain or fade in importance; idioms of the present, associated with the concerns of contemporary life and responses to social change; and emerging idioms. The latter may emerge from several places. For example, they may be inadvertently introduced by medical systems in the form of new syndromes or risk assessment technologies. They may be intentionally fostered by stakeholders making a profit

[10] In a forthcoming article on the localization of healing in a global environment, Jen Thompson, Cheryl Ritenbaugh, and I argue that Gardner's (1993) concept of "multiple intelligences" needs to figure into our consideration of why individuals experience and express distress in particular ways and gravitate toward particular types of healing modalities and healers.

from the biomedicalization of life, such as pharmaceutical companies, that are attempting to increase product sales through marketing strategies that play off of old as well as new sources of distress.

Idioms of Distress and Cultural Syndromes

Idioms of distress are socially and culturally resonant means of experiencing and expressing distress in local worlds. They are evocative and index past traumatic memories as well as present stressors, such as anger, powerlessness, social marginalization and insecurity, and possible future sources of anxiety, loss and angst. Idioms of distress communicate experiential states that lie on a trajectory from the mildly stressful to depths of suffering that render individuals and groups incapable of functioning as productive members of society. In some cases, idioms of distress are culturally and interpersonally effective ways of expressing and coping with distress, and in other cases, they are indicative of psychopathological states that undermine individual and collective states of well-being. When experienced along with significant pathology, idioms of distress express personal and interpersonal distress beyond that associated with universal disease processes.

In my original article I called attention to a wide variety of coexisting idioms of distress in South India. At first blush, some of these idioms appear commonplace, while others stand out as being culturally unique. One must be careful not to generalize too quickly. For example, paying more or less attention to cleanliness and order may appear to be a common means of expressing distress cross-culturally and, in extreme cases, to be related to a universal psychological condition: obsessive compulsive disorder. But in India, among Brahman women, cleanliness takes on deep cultural meaning associated with purity and pollution as well as one's biosocial identity and all that it entails. Being inattentive to rules governing purity and pollution is meaningful in a way that differs in quality from the expression of distress in the United States by a marked shift in one's normal state of order and hygiene.

Over the last three decades, I have written about many different idioms of distress. I have paid particular attention to cultural dimensions of somatic idioms of distress (e.g., Nichter 2001, 2002, Nichter 2008a, b), a complex topic addressed by many insightful anthropologists and psychiatrists in a wide variety of cultural and clinical settings.[11] I have invested an equal amount of time investigating less widely recognized behaviors that serve as idioms of distress. Here are just five.

1. Medicine-taking behavior: Distress may be expressed through requests for medicines, medicine refusal and nonadherence, self-medication with prescription, nonprescription and alternative medicines and the display of medication

[11] For example, Kirmayer and Young (1998) have documented cases in which somatic states may be indicative of any combination of seven things: an index of a disease or disorder, a symbolic expression of intrapsychic conflict, an indication of specific psychopathology, a culturally salient idiom of distress, a metaphor for experience, an act of positioning within a local world or a form of social commentary or protest. See also Hinton and Good (2009).

(Nichter and Vuckovic 1994; Nichter and Thompson 2006; Quintero and Nichter 2010).[12]

2. Use and reframing of biomedical disease nomenclature: Distress may be expressed by stating that one is experiencing an experiential state associated with a biomedical disease category that has or has not been diagnosed by a practitioner. In the first case, the meaning of a biomedical diagnosis such as hypertension may be reinterpreted culturally to refer to a condition affected by psychosocial or economic tension (Huertin-Roberts 1993; Strahl 2003). In the second case, psychiatric terminology (depression, ADHD, PTSD) may be used as an idiom of distress as well as a form of self-diagnosis (Ng 2009; Quintero and Nichter 2010; Summerfield 2001).[13]
3. Use of diagnostic tests: Distress may be experienced as a subjective state of risk that leads one to seek diagnostic tests, and the taking of tests may be engaged in as a means of expressing distress to significant others. This is becoming a common phenomenon in India, catered to by both clinicians and a lucrative diagnostic testing industry readily available to the public (Nichter 2002). It is not uncommonly encountered at clinics in the United States and is a dimension of biomedicalization (Clarke et al. 2003) on which little research has been conducted.
4. Health-care seeking: Distress may be expressed through the seeking of health care within a pluralistic health-care arena as well as the evaluation of care received as being effective or ineffective above and beyond the diagnosis (Nichter and Nordstrom 1989). Searching for a practitioner and diagnosis from an alternative health-care system may constitute a rejection of the way in which a person's state of distress was diagnosed and treated by the mainstream system previously (Nichter and Thompson 2006) and an expression of agency in the face of distress.
5. Changes in consumption patterns, with smoking as a case in point: A marked increase in one's level of smoking is strongly associated with negative states of affect and is portrayed in the media as a means of both coping with distress and displaying distress. Distress is both experienced and communicated nonverbally at the site of the body through smoke signals that are picked up by others on the basis of how much one smokes, as well as when and how one smokes and whether one shifts from smoking socially to smoking alone (Nichter et al. 2007).

[12] Medicine exchanges may also constitute an idiom of concern (Nichter 2008a), and medicine requests may also be an idiom for establishing a positive identity associating pain with hard work and sacrifice for one's family (Trnka 2007).

[13] Non-biomedical practitioners may borrow from biomedical or psychiatric registers as a means of bolstering their own social status or providing patients with new or hybrid illness identities, a process know as "enregisterment" (Wilce 2008). In this case, biomedical terms take on local meaning. Notable shifts in the classification of mental states have occurred within psychiatry, influenced by historical factors, social and economic exigencies, and advances in scientific research. These shifts in turn influence the way in which the public labels, interprets, experiences, and responds to distress. For example, see Horwitz (2010) on shifts in the boundaries between anxiety and depression over the last 50 years in the USA, and the way in which depression has come to eclipse anxiety in both biomedical practice and the public imaginary.

The term *cultural idioms of distress* is utilized in DSM IV. While I see cultural dimensions of most transactions involving idioms of distress and am critical of how the term "cultural" has been used only to describe "other cultures," let me suggest that the term cultural idioms of distress be reserved for culturally prescribed ways of communicating distress. This use of the term would identify widely recognized and commonly shared ways of articulating distress for which there are culturally specific ways of acknowledging and managing these experiences and expressions of distress. Cultural idioms of distress would not be seen as existing in isolation and frozen in time but, instead, as tied to culturally salient types of interaction that make sense in context. By definition, cultural idioms of distress would be semantically and pragmatically effective, as well as largely nonstigmatized ways of communicating distress, of which psychiatrists should be made aware.

In what way do they differ from cultural syndromes? As I see it, a cultural syndrome is a widely recognized prototypical cultural ailment that encompasses a fuzzy set of associations coalescing around one or more core cultural symbols. Individuals' own experiences of a cultural syndrome vary but have a family resemblance to the prototype. Cultural syndromes may take the form of either a culturally recognized and indigenously diagnosed/divined cultural illness or types of behavior recognized by practitioners to reflect particular types of distress in an historical context. An example of the former is *dhat* syndrome in India. Dhat syndrome is associated not just with semen (actually *ojus*) loss among men, but with a whole host of symptoms associated with perceptions of ethnophysiology as well as religious ideology. Semen loss is an idiom of distress in many cultures, and in India it is a cultural idiom of distress having unique characteristics. The affliction is a syndrome because it has a prototypical form of affliction diagnosed by indigenous specialists as well as being an affliction targeted and reinforced by pharmaceutical companies through the sale of both traditional and modern products. The syndrome is not static, but like all cultural syndromes open to cultural elaboration and reinvention.

An example of the latter type of syndrome is Gulf syndrome. I first heard Indian doctors talk about Gulf syndrome in the late 1980s while conducting research on the rising popularity of diagnostic tests (Nichter 2002). Indian "guest workers" contracted to work in the Arabian Gulf would often return to South India after long absences from home and check into a local clinic to have a battery of diagnostic tests run on themselves and/or their wives. In this case, it was not so much specific sets of symptoms that characterized Gulf syndrome as it was types of behavior that articulated subjective states of vulnerability and distress. The syndrome served as an idiom of distress for both the migrant worker and the spouse. Both used the results of tests as traces of some truth about how they had been treated abroad, (for the worker) or at home and at the mercy of in-laws, (for the spouse), and the toll that hard work or neglect had taken on their bodies. Notably, the syndrome enabled extended family members an opportunity to express concern about the couple and engage in idioms of care and concern.

I would argue that cultural syndromes often function as idioms of distress, but not always. And I would caution us to differentiate between when a cultural syndrome serves as an idiom of distress and when experiencing a cultural syndrome causes

distress. Let me briefly explain the difference with an example. In my original Idioms of Distress article, I noted that leukorrhea in South India was seen as a counterpart to semen loss in men, albeit with a different but overlapping set of ethnophysiological and moral associations. Some women chose to call attention to this common somatic complaint as an idiom of distress, while most did not, and some practitioners became renowned for diagnosing this complaint as the cause of a wide variety of problems, in addition to recognizing it as an idiom of distress. Much research has been conducted since 1981 confirming that many Indian women do indeed associate leukorrhea with stress and anxiety and employ complaints of leukorrhea as an idiom of distress (Patel et al. 2005). Public health researchers have expressed concern that such complaints decrease the utility of community-based algorithms designed to identify cases of reproductive tract infections and sexually transmitted infections (Trollope-Kumar 2001). But as Jejeebhoy (2005) points out, many other Indian women are ashamed to reveal that they have this condition because of its associations with sexual infidelity in their community. In such cases, women may suffer from *safed pani* (*white leaking out*) as a cultural syndrome, endure this illness in silence and suffer psychological and emotional distress because they are afraid of being stigmatized. I ran into a similar phenomenon in northeastern Thailand: the cultural syndrome *mot luuk*, a condition also associated with leukorrhea. Many Thai medical practitioners and epidemiologists suspected that women often complain about Mot Luuk as an idiom of distress indexing interpersonal and social problems. Research revealed that there were several social reasons women refrained from using this problem as a way of complaining about interpersonal relations and life problems to husbands or neighbors. Mot Luuk was thought to be caused by several factors ranging from hard work and poor hygiene to male infidelity. Regardless of cause, the distress related to the condition was far more related to ethnogynecological ideas about how the illness might transform into a more serious illness category, *maleng paak mot luuk*, associated with cervical cancer (Boonmongkon et al. 2001).

Critiques of Idioms of Distress

Two critiques leveled against how some people think of idioms of distress are worth visiting. Kirmayer and Young (1998) have written that "the notion of 'idiom of distress' may be misleading, to the extent that such "idioms" are assumed to be highly structured and entirely conventional ways of expressing distress. In reality, the meanings expressed through these idioms are often fragmentary, tentative, and even contradictory." I could not agree more, and would argue that a transactional approach attentive to the semantics, pragmatics and micropolitics of communicating distress leads us to an understanding of idioms based far more on presentation and negotiation than on static representations.

Lee et al. (2007) have drawn attention to the way in which labeling embodied emotional expressions as metaphors or idioms leads us to think of them as figurative, and not genuine, and to valorize meaning above the lived experience of sensations linked to emotional states. Their warning is something I took to heart and

tried to address in a call for a sensorially engaged anthropology (Nichter 2008a, b). The study of somatic idioms of distress demands more than a clever mind and the ability to "figure out." It requires of the researcher and clinician the ability to be present and engage in a somatic mode of attention that is reciprocal and humbling.

What do the Articles in this Issue Add to the Idioms-of-Distress Agenda?

Let me briefly comment on the papers in this issue and highlight ways in which they take an idioms-of-distress agenda in new directions. In many ways, the Pedersen et al. (2010) article on Llaki and Nakaray in Peru exemplifies the research agenda that I have been describing. It is attentive to variability in the expression of distress, the polysemic and multivocal nature of idioms and the historical change in the meanings of idioms, which are ever being transformed and invested with new meaning. This study into the use of idioms of distress among a people having a long history of aggression, violence and suffering is instructive on several levels. The reader learns how longstanding idioms of distress associated with colonial history have changed to enable the communication of distress over present levels of material impoverishment and insecurity. And the reader encounters hybrid idioms that reflect both cross-fertilization between Quechua and Spanish and the infusion of local meaning into terms such as *traumadu*, which now indexes learning disabilities in school and antisocial behavior among youth.

Kohrt and Hruschka's (2010) multimethod study of trauma in Nepal does not break new conceptual ground, but provides a wealth of practical observations about how and how not to carry out research on trauma. Their study aptly illustrates why using a decontextualized survey on the prevalence of trauma in a community might yield invalid results. Their research reaffirms the observation that trauma is experienced, described and interpreted in a variety of cultural ways in most societies. It is not something a researcher or clinician can adequately document by asking about trauma in general or by using some general descriptor. The authors also encourage fellow researchers and clinicians to consider the politics of responsibility related to the occurrence of traumatic events, and the stigma that might adhere to particular explanations. For example, they draw attention to karma as a powerful, albeit potentially stigmatizing, frame for interpreting trauma among a particular stratum of society in Kathmandu. In my own research on karma in India (Nichter and Nichter 2010), I have found that karma as an ultimate explanation for affliction is used far more by others than by oneself, and is often preceded or accompanied by other, more proximate causes of misfortune. The authors remind us that it is important to consider causality, responsibility and morality when researching trauma, as well as how the structure of an interview may influence knowledge produced. Interviews about distress may give us much different data than observational research on the presentation of idioms of distress in different types of natural settings and to different types of audiences. Future studies might also pay closer attention to the multiple voices (voiced positions) that emerge during interviews revealing dialogical relationships both within and between people (Hermans 2001, Hermans and Kemphen 1993).

Lewis-Fernández et al. (2010) provide us with a sound example of why it is important for those in the mental health field to differentiate between different cultural ways of communicating distress. On the basis of ethnographic research, members of this team of researchers had previously observed that the umbrella category "nervios" encompasses three distinct ways of experiencing and describing types and states of distress. The present quantitative study was set up to test a number of hypothesis which were generated by qualitative research and observations within clinics. Research was conducted in a highly traumatized population affording the team an opportunity to study the correlation between various idioms of distress, exposures to trauma and types of psychopathology. What struck me most about this study was its attention to detail, demonstration of transdisciplinary thinking, and productive use of mixed methods. Like the study by Kohrt and Hruschka, I was stuck as much by method contributions as content contributions. I very much appreciate the team's take-home message to clinicians: don't just screen for psychiatric diagnostic categories like PTSD or MDD, be attentive to cultural expressions of distress. Why? Not just because they signify states of interpersonal and social angst that might not fit psychiatric nosology, but because they may independently be associated with destructive behavior. This certainly resonates with my experience working in clinics in the USA and abroad.

Van Duijl et al. (2010) provide a case study that speaks to the long-standing interest cultural psychiatry has had in the relationship between spirit possession, trauma and psychopathology. Not unsurprisingly, the authors find that most of those with a history of possession attribute their unsolicited possession states to cultural explanations such as pending rituals to ancestor spirits, bewitchment or fears of sorcery associated with social and moral conflicts of one type or another. Those with a history of possession were found more likely to report traumatizing events in their lives. They were also more likely to report psychoform and somatoform dissociative symptoms when administered standardized tests. So where does that leave us? Like many anthropologists before them, the authors point out that spirit possession is not a monolithic phenomena and that there are different types of spirit possession within local cosmologies interpreted in a variety of ways. When unsolicited and undesired, possession is treated in ways that shed light on the works of culture. The authors point to possession as serving as an idiom of distress that gets social attention. There are many questions that remain to be answered about the effectiveness of works of culture to treat heightened states of distress related to specific traumatic events vs. a more generalized fear of vulnerability. How is effectiveness judged? What is the half life of treatment effectiveness? How do family members and extended kin respond to both possession states and forms of treatment that may entail significant expenditure? And following Halliburton (2005), how has the incidence, framing and staging of possession shifted in the presence of other therapeutic modalities, emerging idioms of distress, and forces of modernity? Halliburton observes in Kerala, India that managing possession continues to be a work of culture, but a work that now deals with a more homogenized form of possession which interfaces with changing ideas of psychological vulnerability gleaned form newspaper advice columns and other sources of pop psychology. We need to know far more about how

possession cults, exorcism and the works of culture are responding to a changing world[14].

Hinton et al. (2010) present an extraordinarily detailed and highly instructive case study of the cultural syndrome *khyâl* (wind attacks) commonly suffered by traumatized Cambodian refugees and closely associated with PTSD. Indeed, the form and trajectory of *khyâl* attacks strongly influence the manner in which PTSD and states of anxiety are culturally experienced in what the authors (following Kleinman 1986) refer to as patients' trauma-somatic reticulum (cultural and social structures and expectations that cause particular somatic symptoms to manifest or be amplified) and trauma-social reticulum (social and cultural structures that result in trauma having certain social effects). The cultural syndrome *khyâl* is sociosomatic (Kleinman and Becker 1998) in that it interconnects trauma experience, social experience and somatic experience in recursive bioloops (Hacking 1999; Kirmayer and Sartorius 2009) that tends to result in trauma-related distress taking the form of panic attacks. *Khyâl* attacks are an idiom of distress as well as a good indicator of PTSD. As noted by Lewis-Fernández et al. (2010) cultural idioms of distress and syndromes are not just a more experience-near way of comprehending a patient's experience of trauma, but an important way of understanding cultural response to trauma, more so than with a more culturally remote construct like PTSD. On the other hand, biological processes associated with PTSD may well be a trigger for the cultural form of panic that ensues. What I found thought-provoking was how the authors end their piece with reference to how lay interpretations of war-related syndromes, including impressions of their trajectory and how they should be treated, provide new idioms of distress as well as becoming cultural syndromes in their own right.

Abramowitz (2010) provides us with one of the most powerful ethnographies I have read to date on psychiatrist and medical humanitarian group attempts to appropriate and translate cultural syndromes while struggling to deliver mental health services to traumatized populations. Her description of "pigeon psychiatry" raises issues that pave the way for future studies of the medicalization of idioms of distress as well as the way in which the taking of psychoactive medications (antidepressants and so on) alters the narrative self (Kirmayer 2002).[15] Abramowitz documents how a cultural idiom of distress is at once emptied of its meaning, reframed by Western psychology and then sold back to a local population as a comorbid disorder (*open mole* with PTSD, depression or anxiety) for which there are medication fixes. The demand for psychoactive medications as a form of symbolic capital having immediate demonstrative effects increases and the Liberian

[14] For example, I know of ritual specialists in South India (*Mantra Vaidi*) who are currently using psychoactive drugs in their practice, and find that they enhance their work of culture.

[15] On the medicalization and pharmaceuticalization of idioms of distress, see the work of Rozemberg and Manderson (1998) in Brazil and Ecks and Basu (2009) in India. Ecks and Basu document the floating market and increasing demand for psychopharmaceuticals in India. Rose (2006) provides a useful discussion of the pharmaceuticalization of problems of living and bracket creep of psychiatric diagnosis. Applbaum (2006) provides a sobering account of the pharmaceutical industry's crusade to raise public awareness about psychiatric diagnosis and willingness to take psychoactive drugs to manage an increasing array of life problems.

population learns to produce narratives in short order that fit the diagnosis and justify long-term drug use. One can only wonder how long supplies of medicine can be sustained, what will happen when medications are interrupted, how the population will interpret and respond to negatively valued side effects and what other idioms of distress will take the place of *open mole*?

De Jong and Reis (2010) remind us that idioms of distress need to be considered in socio-political contexts and not just be seen in terms of psychological processes intrinsic to individuals. At the level of symbolic protest, they constitute a language for social suffering that cannot overtly be articulated in socio-political contexts where doing so causes a threat to both those who suffer from structural violence and those in positions of power. In the case study provided, an individual expression of distress associated with young barren women in Guinea Bissau is appropriated and used by those in a social movement to communicate post-war related traumatic stress and suffering. This is accomplished through the use of symbols having powerful cultural resonance.

Hinton and Fernandez's introduction to this issue brings my commentary on idioms of distress full cycle because it raises the question, So what? Aside from its intellectual merit, and the lessons it teaches us about social processes and human communication, of what clinical and problem-solving utility is an idioms-of-distress assessment of traumatized individuals and communities? I have spent a long time thinking about this over the years. It was reassuring for me to look at the list of utilities identified by these champions of a new cross-cultural psychiatry and to see where productive transdisciplinary thinking has taken the field. As I reread the introductory piece, I could not help but reflect on just how far the field has come since "Idioms of Distress" was first published, 30 or so years ago. Reading the history of DSM IV, and realizing how few of an expert panel's recommendations about culture made it to the final product, reminds me of how far we have yet to go.

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