

## CULTURES IN PSYCHIATRIC NOSOLOGY: THE CCMD-2-R AND INTERNATIONAL CLASSIFICATION OF MENTAL DISORDERS

**ABSTRACT.** This essay reviews the Chinese Classification of Mental Disorders, Second Edition, Revised (CCMD-2-R, 1995), by assuming the theoretical stance that symptom recognition, disease construction, and taxonomic strategy in psychiatry reflect, and are constrained by, the cultural norms and values as well as the political and economic organizations of the society in which they are embedded. The CCMD-2-R is an ethnomedical classification grounded in both symptomatology and etiology, in which Chinese psychiatrists seek to conform with international classifications on the one hand, and to sustain a nosology with Chinese cultural characteristics on the other. Although broad similarities between the ICD-10 and CCMD-2-R are evident, their blending is legitimately incomplete. Thus, the particular additions (e.g., travelling psychosis, *qigong* induced mental disorders), deletions (e.g., somatoform disorders, pathological gambling, a number of personality and sexual disorders), retentions (e.g., unipolar mania, neurosis, hysteria, homosexuality), and variations (e.g., depressive neurosis, neurasthenia) reveal not only the changing notions of illness but also the shifting social realities in contemporary China. The CCMD-2-R will be widely used by Chinese psychiatrists and should standardize diagnostic practice and facilitate research, but its impact on everyday clinical work and psychiatric training remains to be evaluated. For Western researchers, it is one avenue for achieving an understanding of the Chinese social world, and should usefully be contrasted with the ICD-10 and DSM-IV as the move towards an international nosology continues.

Logic, deprived of common sense, becomes inhuman, and common sense, deprived of logic, is incapable of penetrating into nature's mysteries.

We have to get back to a way of thinking which is more impatient to be in touch with reality, with life, and above all with human nature, than to be merely correct, logical and consistent.

Yutang Lin,  
*The Importance of Living* (1977, pp. 397 and 406)

Categories are the outcomes of historical development, cultural influence, and political negotiation. Psychiatric categories – though mental illness will not allow us to make of it whatever we like – are no exception.

Arthur Kleinman,  
*Rethinking Psychiatry* (1988, p. 12)

Although every community at one particular time has its preferred notions of health and sickness and favoured arrangement of diseases (Fabrega 1994a; Kirmayer 1991), the need for an international classification of mental disorders has been felt for a long time (Jablensky 1988; Sartorius 1988; Stengel 1959). As the ICD-10 (World Health Organization 1992) and DSM-IV (American Psychiatric Association 1994) schemata are being globalized, it is less commonly known that China, which constitutes over one fifth of humankind, has a national system of psychiatric classification, called the Chinese Classification of Mental Disorders (CCMD). Knowledge of this is not only indispensable for communicating with Chinese psychiatrists and reading their burgeoning literature, but is also a means of understanding the development of psychiatry in China.<sup>1</sup> To the extent that the configuration of symptoms into recognisable syndromes and their designation as mental disorders reflect the core values and political organizations of a society and hence run a social course,<sup>2</sup> the way in which the CCMD has been successively restyled should furnish clues to China's transforming social realities. As Chinese people represent one of the fastest growing ethnic minority groups in many Occidental societies, knowledge of the CCMD may also attune clinicians to certain Chinese forms of distress in an intercultural treatment context. What is more, an examination of its discrepancies from Western nosological systems may encourage reflective self-criticism on the one hand, and be rewarded with insights on both the universality and particularity of human behaviour on the other (Kleinman 1988).

China has one of the longest and richest written records of mankind. But modern China has gone through numerous wars and disasters, which shattered its social structure and stalled its mental health movement (Chen 1995; Kleinman 1986). Attempts to classify mental disorders only began around 1958 (Chen and Chen 1962; Xu et al. 1993), and had been influenced by Russian psychiatry (e.g., Giljarovskij 1954, in Stengel 1959). The first published classificatory scheme appeared in 1979 (Table I). This was revised and named the CCMD-1 in 1981, and was further modified in 1984 (Chinese Society of Neurology and Psychiatry 1979, 1982 and 1985).

This interest in nosology had gained momentum because of both medical and social factors, including the availability of specific modalities of pharmacological and psychological therapies, psychometric instruments, the introduction of the DSM-III-R into China in 1987,<sup>3</sup> and the increased attention given by the Chinese authorities to mental health matters as the living conditions of its people improve. The CCMD-1 was subsequently revised and tested on 22,285 out-patients and 8,061 in-patients in 77 mental health facilities all over China (Chen 1995). These

efforts culminated in the publication of the CCMD-2, which represented a marked change from the previous classificatory schemes. For the first time in China, operationalized criteria for a broad range of diagnostic categories became available (Chinese Medical Association 1989).

The nationwide adoption of the CCMD-2 in the subsequent five years, the recognition of certain inaccuracies it contained (e.g., Feng and Wang 1992), and the anticipated publication of the ICD-10, led again to various revisions that began in September, 1992. Through a series of meetings, drafting and field tests, the CCMD-2-R (Second Edition, Revised) was finally published in January, 1995 (Chinese Medical Association and Nanjing Medical University 1995).

In contrast with the CCMD-2, the CCMD-2-R task force was under a stronger influence from the ICD-10 than the DSM system.<sup>4</sup> Among Chinese psychiatrists, the process of unifying the CCMD-2-R with the ICD-10 is metaphorically called *jie gui* ("joining rails"), and the resulting hybrid is pragmatically described as *da tong xiao yi* ("a general resemblance with small differences").

Compared to the ten groups of mental disorders in the early Chinese classification (Table I), certain groups are fused while three new groups are added to the CCMD-2-R. These include "mental disorders due to psychoactive and non-dependent substance use (10-11)", "physiological disorders related to psychological factors (50-59)", and "other mental disorders, forensic conditions and conditions closely related to mental health (90-99)". As a result, the CCMD-2-R and the ICD-10 share a broadly comparable architecture (Table II).

Opinions regarding the need for a national classification are, however, divided, reflecting to some extent China's typically syncretistic response towards foreign influence (Kleinman 1986: 34). Some Chinese psychiatrists feel that the CCMD-2-R is redundant because the ICD-10 is a comprehensive system that will not only serve them adequately, but also expedite inter-specialty<sup>5</sup> and international communication (Jia 1995; Xu T.Y. 1994). So Xu Y.X. (1994), a leading psychiatric theoretician, recommends that all Chinese psychiatrists "should seriously learn and accurately use it".

But Chinese psychiatrists have had over five years of experience with the CCMD-2 system, which also supplies professional status to their discipline. Specifically, many of them believe that the CCMD-2-R has special advantages, such as simplicity, stability, the inclusion of culture-distinctive and serviceable forensic categories, and the exclusion of otiose Western diagnostic categories. Linguistically, it is easier to use than the Chinese version of the ICD-10, which contains excessively long sentences,

TABLE I  
The early classification of mental disorders in China (1979)

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1.	Organic brain disorders
2.	Mental disorders due to physical diseases – infective, toxic, visceral, endocrine, metabolic and other diseases
3.	Schizophrenia – simple, hebephrenic, catatonic, paranoid, latent, residual, deteriorated, and other types
4.	Affective disorders
	a) manic depressive disorder – manic, depressive, bipolar, and other types
	b) involuntional depression
5.	Reactive psychosis
	reactive somnolence, reactive excitement, reactive depression, reactive paranoia
6.	Other psychoses
	a) paranoid psychosis – paranoia, paranoid state, involuntional paranoid state
	b) periodic psychosis
	c) schizoaffective disorder
7.	Neurosis – neurasthenia, anxiety neurosis, hysteria, obsessive compulsive neurosis, phobia, hypochondriasis, neurosis referred to viscera, other neuroses
8.	Personality deviation
	pathological personality, sexual perversion
9.	Mental deficiency – mild, moderate, severe types
10.	Mental disorders in childhood

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awkward terms, and syntactical problems<sup>6</sup> (Jia 1995; Young 1994). In a “one copy per person” fashion, it is particularly liked by younger generations of Chinese psychiatrists, and will be used on a broad front by clinicians throughout China. Based on the belief in “a small revision every five years, and a major change every ten years”, the CCMD task force is committed to assimilating new knowledge and periodic revisions (Editorial Board of the Journal of Clinical Psychological Medicine 1994).

Unlike the ICD-10 which is divided into clinical, research and primary care versions, the CCMD-2-R is an all-purpose document. The word disease is avoided, while “disorder” (*zhangai*) is understood in a way similar to that of the ICD-10 or DSM-IV, in referring to a clinically recognisable set of symptoms or behaviour associated with distress or disability. No attempt is made to distinguish it from the deeper meaning of “diagnosis,” which connotes an underlying etiology, a situation that will not be solved by any system of classification until a better understanding of disease process is achieved in psychiatry (Cooper 1995). Nonetheless, as etiological factors can determine important treatment decisions and

TABLE II  
Outlines of the CCMD-2-R and the ICD-10

CCMD-2-R	ICD-10
Mental disorders due to organic brain disorders and physical diseases (00-01)	Organic, including symptomatic, disorders (F00-F09)
Mental disorders due to psychoactive and non-dependent substance use (10-11)	Mental and behavioural disorders due to psychoactive substance use (F10-F19)
Schizophrenia and other psychotic disorders (20-29)	Schizophrenia, schizotypal and delusional disorders (F20-F29)
Affective (mood) disorders (30-39)	Mood (affective) disorders (F30-F39)
Neurosis and psychogenic mental disorders (40-41)	Neurotic, stress-related and somatoform disorders (F40-F48)
Physiological disorders related to psychological factors (50-59)	Behavioural syndromes associated with physiological disturbances and physical factors (F50-F59)
Personality disorders, impulse disorder, and sexual perversion (60-62)	Disorders of adult personality and behaviour (F60-F69)
Mental retardation (70)	Mental retardation (F70-F79)
Mental disorders in childhood and adolescence (80-86)	Disorders of psychological development (F80-F89)  Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90-F98)
Other mental disorders, forensic conditions and conditions closely related to psychological health (90-99)	Unspecified mental disorders (F99)

prognosis, the CCMD-2-R strategy of classification is both etiological and symptomatological. Professor Derson Young (1994), a Chinese luminary on psychiatric nosology, submits that an approach based exclusively on symptomatology, or any other single characteristic, is "not feasible."<sup>7</sup> In his view, the symptomatic overlap of most mental disorders and the limited present knowledge about their etiology should make a mixed classification a realistic compromise.

Zheng and coworkers (1994) demonstrated that the reliability and validity of the CCMD-2 and the DSM-III-R were closely compatible in most diagnostic categories, such as schizophrenic, delusional, bipolar and depressive disorders. Discrepancies, however, remained in the diagnosis

of neurasthenia and hysteria. In the national field trial of the CCMD-2-R involving 55 experienced Chinese psychiatrists and 750 patients of various diagnostic categories, the CCMD-2-R demonstrated high kappa values of interrater reliability ( $> 0.97$ ) and of consistency (0.89) with the CCMD-2. Using previous clinical diagnoses as a "gold" standard of validity, an overall kappa of 0.80 was found for the range of diagnostic categories (Survey and Test Group for the CCMD-2-R 1996). More recently, Zhou and coworkers (1995) further demonstrated that the reliability of the CCMD-2-R and the ICD-10 were closely compatible ( $\text{kappa} = 0.89$ ) in the different forms of mood disorders. These results led academic Chinese psychiatrists to maintain that the CCMD-2-R is "comprehensible, acceptable, and feasible" (Chinese Medical Association and Nanjing Medical University 1995: 164–170; Xu et al. 1993), but most of them are aware that further validation work is awaited.

Much like the *Desk Reference to the DSM-IV* or *Pocket Guide to the ICD-10 Classification of Mental and Behavioural Disorders*, the CCMD-2-R is published in the form of a handbook of 238 pages. Costing six *yuan* (about US \$0.7) per copy, it contains operationalized criteria for all diagnostic categories, and the equivalent or closest ICD-9 and ICD-10 codes alongside the diagnostic headings.<sup>8</sup> The CCMD-2-R begins with an "Instruction for users", and ends with 5 appendices, including: (1) a Chinese-English index for listed mental disorders, (2) a report of the major field trial of the CCMD-2-R, (3) a list of ICD-10 categories and their codes, (4) a list of DSM-IV categories and their codes, and (5) an alphabetized (according to *Hanyupinyin*)<sup>9</sup> list of definitions of mental disorders, symptoms, and culture-related terms such as *qigong*. It includes personality disorders and mental retardation but is not multi-axial in nature. For each major diagnostic category, two subgroups ("other" and "unspecified") of mental disorders exist to accommodate uncommon or atypical variants.

Although the earlier CCMD schemata were cursorily presented in the English literature before (e.g., Shen 1988 and 1994), a detailed review has been lacking. Because of this, and the fact that a significant body of salient articles which discussed it are published in Chinese, this paper introduces the CCMD-2-R in its coded order<sup>10</sup> and selectively reviews areas of cross-cultural concern. Comparison is made mostly with the ICD-10 but, where appropriate, the DSM-IV is also referred to. To put the discussion in context, reference was made to relevant articles obtained from a hand search of three major psychiatric journals published in China, namely, *Chinese Journal of Neurology and Psychiatry*, *Chinese Journal of Nervous and Mental Diseases* (1990–1996), and *Journal of Clinical Psychological Medicine* (1991–1996). The paper also drew upon other Chinese journals

and personal contacts with Chinese psychiatrists, including my involvement in national workshops held in China on the CCMD-2-R, ICD-10 and DSM-IV.

A cautionary statement must be appended that China is a huge country with over 1.2 billion people and 56 ethnic groups (91% are Han) (Chen 1995). Spectacular pluralism and diverse levels of acculturation to modern life logically exist among people addressed as "Chinese" (or for that matter, "Western") in this paper. The marked socioeconomic discrepancies between urban and rural China, for example, almost ensure that any generalization I venture will oversimplify a complex reality. A lively sense of skepticism on the part of the reader is therefore recommended.

#### MENTAL DISORDERS DUE TO ORGANIC BRAIN DISORDERS AND PHYSICAL DISEASES (00-01) (F00-F09)

This block of organic disorders is similar to those of the ICD-10. In both systems, mental disorders due to organic (brain) and physical diseases (i.e., all disorders attributable to an organic cause) are grouped in the same block.

As in the ICD-10, to invoke the word "organic" is not to imply that other disorders do not have cerebral substrate. It simply means that the syndrome so classified can be attributed to an independently diagnosable cerebral or systemic disease. This differs from the DSM-IV which has abolished the major heading of "organic mental disorders" because "it implies that the other disorders in the manual do not have an 'organic' component" (p. 776). Instead, the DSM-IV distinguishes between "cognitive disorders" and "mental disorders due to a general medical condition."

The CCMD-2-R task force is conservative towards terminological alterations. Young (1994) criticized the DSM system as *zhao ling xi gai* ("issue an order in the morning and rescind it in the evening"). He argued that the term "cognitive" will likewise imply that other DSM-IV disorders do not have cognitive manifestations. This confutes the fact that cognitive symptoms are commonly exhibited by patients with "functional" mental disorders. Moreover, in the cases of dementia and delirium, "cognitive" may be seen to under-value the variety of behavioural and psychotic symptoms that accompany these disorders. Cognitive impairment, in fact, is not invariably present in all stages of dementia.

Perhaps the most salient implication of this section of the CCMD-2-R is that neurological conditions that do not cause mental disturbance may no longer be a principal domain of Chinese psychiatrists. For example, although patients with epilepsy have been treated by both psychiatrists and

neurologists in China, the fact that only "mental disorders due to epilepsy" are included will help disconnect neurology and psychiatry and diminish the organic orientation of Chinese psychiatric practice.<sup>11</sup>

MENTAL DISORDERS DUE TO PSYCHOACTIVE AND NON-DEPENDENT  
SUBSTANCE USE (10-11) (F10-F19)

The ICD-10 category of "mental and behavioural disorders due to psychoactive substance use" is expanded to include "non-dependent substance use" (11). The CCMD-2-R task force believed that in developing countries such as China, various non-dependent substances (e.g., pesticides, poisonous mushrooms, carbon monoxide, atropine, lead and mercury) also commonly induce mental disorders (e.g., Cai and Li 1991). As "abuse" is often not involved in these conditions, they do not fit into the ICD-10 category of "abuse of non-dependence-producing substances" (F55). Instead, they have to receive dual codes from Chapter V and other parts of the ICD-10. For example, dementia caused by carbon monoxide poisoning will be coded as F02.8 (dementia in other specified diseases classified elsewhere) and T58 (carbon monoxide poisoning) respectively. Jia (1995) felt that this is cumbersome for Chinese psychiatrists as they are usually unfamiliar with the entire ICD-10.

Although alcoholism exhibits substantial regional variations in China, its overall prevalence is considerably lower than in the West (Chen 1995; Cheung 1991). In keeping with the intention of the CCMD-2-R not to over-medicalize behavioural deviance, alcohol dependence is treated as categorical, and is not subdivided into the ICD-10 categories of "harmful use," "abuse" and "dependence." As China's modernization continues and alcohol-related complications become more common, the medicalization of alcohol abuse as a form of social control will follow logically.

Of the ICD-10 list of psychoactive substances, hallucinogens (F16) are not included since their abuse is very rare. But there is a category of "mental disorders due to foods" (11.4) because mental disorders due to food poisoning are still encountered (Hao 1989). Although the Chinese literature on psychoactive substance use disorders has primarily been concerned with alcoholism and opiates, the pattern and classification of substance abuse will predictably change as a result of the urbanization now taking place rapidly in many Chinese provinces.

SCHIZOPHRENIA AND OTHER PSYCHOTIC DISORDERS (20-29) (F20-F29)

Schizophrenia has been the most researched of all psychiatric conditions in China (Chen 1995). In the CCMD-2-R, the nature of the "active-phase"



symptoms of schizophrenia are similar to those of the ICD-10 and DSM-IV. The presence of at least two out of eight groups of symptoms are required for diagnosis.<sup>12</sup> The major difference lies in the duration criterion and the emphasis given to negative symptoms.

The CCMD-2-R duration criterion for the diagnosis of schizophrenia remains the same as in the CCMD-2, namely, three months.<sup>13</sup> The Chinese task force felt that the ICD-10 criterion of one month will not adequately exclude transient psychoses that turn out to be non-schizophrenic in nature, and will eliminate the clinically familiar category of schizophreniform psychosis, which has a duration of less than three months in the CCMD-2-R, rather than one month as in the DSM-IV. Intended or not, another reason could be to avoid stigmatizing acute psychotic patients who may have a good prognosis.<sup>14</sup>

Although the DSM-IV accepts "prodromal" or "residual" symptoms of schizophrenia within a duration criterion of six months, Young (1994) contended that these symptoms are not well defined and overlap with "positive" symptoms. They are therefore not used as diagnostic features in the CCMD-2-R, except in the residual form of schizophrenia. Young also commented that a six month criterion would preclude most patients from receiving a firm diagnosis well after they are recovered and discharged from hospitals. Nonetheless, to the extent that the six month duration in the DSM-IV may include only a minimum of one month of "active" symptoms, the CCMD-2-R criteria are potentially more stringent than those of the DSM-IV. This should help reduce the overdiagnosis of schizophrenia, which still occurs in certain parts of China (Pearson 1995a).

Frequent changes in the duration criterion of schizophrenia not only attest to the arbitrariness of one of the most "biological" disease categories in psychiatry, but are also undesirable from the vantage point of research. Although they may not affect those who work with chronic patients, they do adversely influence such research work as comparative studies of incidence and outcome (Cooper 1995). To the extent that schizophrenia is organized as much by taxonomies as it is by disease processes (Kleinman 1988), an internationally unified criterion seems desirable in the future.

The CCMD-2-R preserves "paranoid psychosis" (22) and "simple schizophrenia," but excludes "schizotypal disorder." Simple schizophrenia is a controversial entity that was replaced in the DSM-III-R by schizotypal disorder, but is retained in the ICD-10 (F20.6) because of its "continued use in some countries" (p. 12). In early Chinese classifications, simple schizophrenia was listed as the first of several types of schizophrenia (Table I). Clinically, it is a rare but not non-existent condition in both China and Hong Kong. There is the suggestion that outside of hospitals,

it may be a more common cause of deteriorative self-neglect in young adulthood than expected (Wing et al. 1993). Given the fuzzy conceptual boundaries among simple schizophrenia, schizotypal disorder and schizoid personality disorder, the choice of one familiar term in a concise diagnostic system is understandable.

Kleinman (1988) noted that although acute brief psychoses in developing countries are of particular interest to anthropologists because of their enormously different prevalence rates and manifestations cross-culturally, they have not been well studied in psychiatry. As "reactive psychosis" has long been a popular diagnostic category in China<sup>15</sup> (Chen 1995; Shen 1994; Zhang et al. 1991; Table I), the creation of a block of "acute and transient psychotic disorders" in the ICD-10 (F23) has been welcomed by Chinese psychiatrists (Shi 1994). With minor modifications, they are incorporated into the CCMD-2-R, and are expected to stimulate more research into this heterogeneous group of conditions.

Highlighted under "other psychotic disorders" (28) is a condition not found in the ICD-10 or DSM-IV, namely, travelling psychosis (*lu tu jing shen bing*). Jia (1994) gave a detailed account of how it arose from a case study presented during a national conference on forensic psychiatry held in Chengdu in 1986.

On the way from Shandong to visit his son in Xinjiang, a previously well elderly peasant suddenly became psychotic. Under the influence of hallucinatory voices identifying him as an anti-revolutionary, he broke the window and seriously wounded a number of passengers with a knife. Shortly after he got off the train and was arrested, he recovered spontaneously. He was later diagnosed as having suffered from "travelling psychosis." After this incident, further cases of mental disorders closely related to travelling were recognized.

Of special concern were numerous reports (1987–1992) from the Railway Bureau of Wulu Muqi,<sup>16</sup> where a series of long distance travellers were found to become suddenly psychotic. It was particularly alarming that some of them attempted or committed suicide by jumping from the train, while others wounded or killed passengers for no apparent reason. Joint investigations by psychiatrists and the Department of Public Health of the Railway Bureau concluded that multiple causes were likely, including severe congestion, prolonged standing, sleep deprivation, fatigue, cold weather,<sup>17</sup> dehydration, and hypoglycaemia in the northwestern desert areas.<sup>18</sup> That psychosis did not occur in non-congested trains with "soft beds" (*ruanwo*) rather than "hard seats" (*yingzuo*) affirmed the importance of physical etiology (Li et al. 1996). An acute onset ("like tempest and torrent"), disturbed consciousness, disorientation, horrifying illusions

and/or hallucinations, persecutory delusions, panic, motor excitement, impulsive and suicidal jumping off the train, and injuring others were the principal manifestations. Amnesia might occur. The termination of travel, rest and nourishment would lead to spontaneous recovery from within a few hours to 1–2 weeks. More than 95% of the affected subjects did not have any past or family history of mental disorder. They often experienced intense remorse afterwards.

It is notable that over 80% of these conditions happened in trains going in a “downward” or east-west direction.<sup>19</sup> The team of investigators attributed this to psychological factors, in that those who travelled this way were mainly young peasants who left home for the first time to work in Xinjiang. A mixture of homesickness, anxiety and worries (such as over fraud, robbery and unemployment) often overwhelmed these people. This contrasted with “upward” travellers who had earned money and could look forward to returning home and meeting their relatives again.

Even if travelling psychosis has a substantial organic etiology, it nonetheless occurs in the social context of China's drastic market reforms, which result in marked economic regionalism and massive domestic migration. As such population mobility continues, the conditions for travel in many Chinese provinces remain to be improved. It is likely that mental disorders related to travelling may persist or even increase for some time. Granting travelling psychosis a special nosological status has therefore been supported by Chinese psychiatrists. It is expected to promote research into its prevention,<sup>20</sup> and serves decisive judicial functions as offenders so diagnosed may readily be granted a verdict of diminished responsibility or acquittal (Jia 1995; Wang et al. 1994).

Another category not found in the ICD-10 is “periodic psychosis” (25), related to menstrual changes in young women. Published work is limited, but Shi and coworkers (1993) concluded that it was an uncommon disorder with distinctive features. It was acute in onset, short-lasting and recurrent. Manifesting principally as premenstrual psychomotor excitement and fleeting psychotic disturbances, it responded to hormonal therapy with complete remission in between attacks. It is unclear if it represents an extreme form of premenstrual syndrome (*jing qian qi zong he zheng*), which is an uncommonly used disease and illness label in China.<sup>21</sup> Tan and coworkers (1994) also supported its nosological status.

#### AFFECTIVE (MOOD) DISORDER (30–39) (F30–F39)

Cooper (1995) submitted that this is the weakest and most capricious section of all psychiatric classifications because of the lack of clear

boundaries between normality and abnormality, and among the classified categories themselves.

In the past, Chinese psychiatrists were unfamiliar with non-bipolar depression, which had been excluded in former epidemiological studies (Cheung 1991). Since the early 1980s, however, depression has been rapidly popularized (Kleinman 1986; Xu et al. 1993), even though its full spectrum of presentation may be less commonly recognized than in the West. Not too surprisingly, the CCMD-2-R maintains a simple notion of depression, and uses the term *yi yu zheng* ("depressive syndrome") without any subclassification.<sup>22</sup> Even in the 1979 version of the CCMD, depressive neurosis (*yi yu xing shen jing zheng*) was not found.<sup>23</sup> It only started to appear as a form of neurosis in 1982. By contrast, the ICD-10 and DSM-IV provide explicit criteria for subclassifying depression into mild, moderate and severe types,<sup>24</sup> and further specify them according to the presence of somatic, psychotic, catatonic, atypical or postpartum features. Chronic mild depression (i.e., dysthymia) is treated as a distinct form of affective disorder.

Frequent changes in the Western nomenclature of affective disorders, and the research conducted under the jurisdiction of the differing nosological editions, may be perplexing to Chinese psychiatrists. The application of the DSM nomenclature, in which depression is named "major depression," is particularly problematic in a Chinese setting.<sup>25</sup> For although the word "major" may simply mean "greater" or "more important," and major depression may range from mild to severe in intensity, major depression is translated as *zhong xing* (or *zhong du*) *yi yu zheng* ("severe depression") in China. So to translate "severe major depression" as *zhong du zhong xing yi yu zheng* ("severe severe depression") is to court tautology. This confusion is compounded by the fact that some Chinese psychiatrists simply refer to major depression as "depression" (e.g., Han and Yuan 1995).<sup>26</sup>

The impact of this translational difficulty is not to be ignored. There is reason to believe that it could have contributed to some Chinese psychiatrists' misconstrual of Kleinman's seminal study of one hundred patients with *shenjing shuairuo* (neurasthenia) in Hunan, China, where he concluded that 87% of them suffered from DSM-III major depression<sup>27</sup> and responded favourably to tricyclic pharmacotherapy (Kleinman 1982). This paper was published in 1982, when non-bipolar depression had only just started to become a popular diagnosis among Chinese psychiatrists. The term major depression could have been understood by them to mean severe depression.<sup>28</sup>

Although few Chinese psychiatrists read Kleinman's scholarly article in its entirety, the controversies it aroused were enormous (Xu 1990). A

mixed response of anxiety and distrust occurred (Young and Xiao 1993). Inasmuch as neurasthenia was the most common psychiatric diagnosis made in China at that time, the high rate of rediagnosis might insinuate that Chinese psychiatrists had flagrantly missed "severe depression." This interpretation would be unfortunate because Kleinman's emphasis was much less on the cultural constructionist question of whether neurasthenia was misdiagnosed depression, than on the relationship of culture and illness behaviour, in that neurasthenia represented the indigenous idiom for the expression of a varying mixture of depression, anxiety, chronic pain, insomnia, and somatoform disorders.<sup>29</sup> In a less commonly cited follow-up study of some of these neurasthenic patients, anxiety, hypochondriacal and dysthymic disorders in fact outnumbered major depression significantly (Kleinman 1986: 219). Both neurasthenia and depression, Kleinman (1988) later wrote, "might be regarded as the products of distinctive Chinese and American professional psychiatric taxonomies" (p. 13).

Be that as it may, the Hunan study created a nosological crisis among Chinese psychiatrists. It led them to feel "awakened," and to reorganize nosology in a fashion which has increasingly conformed to Western epistemological assumptions. Far from considering whether depression represented a severe form of neurasthenia, Chinese academic psychiatrists now treat as common sense the Western nosological stance that depression was previously "misdiagnosed" as neurasthenia, or that neurasthenia is merely a form of atypical depression.<sup>30</sup>

Although the CCMD-2-R duration criterion (two weeks or more) for the diagnosis of depression is the same as that of the ICD-10 and DSM-4, it requires depressed mood as the "main characteristic" (p. 69) of the condition, in addition to any four out of nine familiar symptoms of depression. In this symptom configuration, the presence of a "depressed mood" can be considered mandatory. This differs from the ICD-10, which requires two out of the three symptoms of depressed mood, loss of interest/enjoyment, and increased fatigability as core diagnostic symptoms,<sup>31</sup> or the DSM-IV, which requires either depressed mood or loss of interest/pleasure as the sole core symptom. According to this broadened Western conception, patients may receive a diagnosis of depression in the absence of a depressed mood.<sup>32</sup> Since affectively ill Chinese patients may be less likely to present with depressed mood than somatic idioms of distress, the CCMD-2-R symptom configuration is arguably over-restrictive and even experience-distancing. But whether this will lead to under-diagnosis of depression in the treatment context is less certain. This is because clinicians are accustomed to the habit of intuitive synthesis, and will rarely make a diagnosis by following a manual strictly. What is more, it is often unclear how "depressed mood"

(e.g., expressed versus observed depressed mood) should be clinically appraised.<sup>33</sup> Pragmatic considerations, such as a therapeutic trial of antidepressants, often override the need to fulfil operationalized criteria.

Unipolar mania existed in the ICD-9 (p. 30), but is no longer found in the ICD-10 or DSM-IV, according to which a patient with two episodes of mania is automatically presumed to be bipolar. But recurrent mania continues to be seen in China and Hong Kong, even though it is seemingly less common than before (Zhao et al. 1991; Zhou et al. 1995). In an eight to ten year follow-up study using the Present State Examination, Xu and Chen (1992) found that eighteen out of twenty four patients with recurrent mania remained genuinely unipolar. These findings question the obligatory labelling of Chinese patients with recurrent mania as bipolar. The possibility that they may exhibit particular biological correlates, treatment response and outcome warrants a separate nosological status in the CCMD-2-R.

A category of "bipolar affective disorder, rapid cycling type" (31.3) is found in the CCMD-2-R. This is not included in the ICD-10, but there is a "specifier" introduced into the DSM-IV (p. 781) to reflect evidence that this presentation may have implications for treatment and prognosis. Like "cyclothymia," its inclusion in the CCMD-2-R shows that nowadays academic psychiatrists in China are quick to respond to novel research findings in the West (Shen et al. 1992).

#### NEUROSIS AND PSYCHOGENIC MENTAL DISORDERS (40–41) (F40–F48)

Despite the use of a mixture of taxonomic strategies, the classification of this highly heterogeneous bag of conditions has remained unsatisfactory (Jablensky 1988; Tyrer 1989).

In Western countries, a unitary concept of neurosis is now thought to be less useful than was formerly believed. The words "neurosis," "neurotic," "hysteria" and "hysterical" have completely disappeared from the DSM-IV, as the DSM-III-R headings of "Anxiety Disorders (or Anxiety and Phobic Neuroses)" and "Dissociative Disorders (or Hysterical Neuroses, Dissociative Type)" are replaced by "Anxiety Disorders" and "Dissociative Disorders" respectively. The ICD-10 similarly shuns the words neurosis and psychosis. It says that neurosis "has not been retained as a major organizing principle," and only uses the words "neurotic" and "psychotic" sparingly (W.H.O. 1992: 3 and 134).<sup>34</sup>

But the word neurosis (*shen jing zheng*) has been used as a popular descriptive and etiological concept by Chinese psychiatrists since the 1950s.<sup>35</sup> Professor Y.X. Xu (1993), author of a widely read book entitled

*Neurosis*, expressed regret for the fact that “neurotic disorder” is neither defined nor described in the ICD-10. He also deplored its rubric of “neurotic, stress-related and somatoform disorders” (F40–F48) as being over-inclusive. For example, it is unclear whether dissociative disorders belong to neurotic, stress-related or somatoform disorders. Similarly, Jia (1995) remarked that the ICD-10, under the influence of the DSM system, has “abandoned” the clinically useful concept of neurosis.

The view that “neurosis” is still a valuable concept is shared by experienced clinicians in other parts of the world. Peter Tyrer (1989) in the U.K., for example, argued for the clinical validity of a “general neurotic syndrome” which consists of a fluctuating *mélange* of anxiety, depressive and personality features that interact dialectically with environmental stressors. Likewise, Yamashita and Koyama (1994) found that most Japanese psychiatrists “indicated reluctance to the partitioning of neurotic disorders into anxiety, somatoform, and dissociative disorders in DSM-III, and preferred the ICD-9 classification of neurotic disorders” (p. 97). So neurosis is preserved in the CCMD-2-R, which emphasizes as its main characteristics chronicity, the presence of predisposing personality and social factors, and the preservation of “insight” (p. 76).

**Consonant with Russian nosology**, three types of neurosis were recognized in early Chinese classifications, namely, neurasthenia, hysteria and obsessive-compulsive neurosis. Not surprisingly, hysteria was found in previous epidemiological surveys to be the second commonest neurotic disorder in China, after neurasthenia (Cheung 1991; Liu 1994).

Although typical accounts of hysterical illness can be found in ancient Chinese medical texts (Liu 1994), the word hysteria itself was not recognized in traditional Chinese medicine. At present, two Chinese translations exist. One renders it as “*yi zheng*” or “*yi bing*” which connotes “sickness of intention” (Xu 1990). Composed ideographically of two basic units which refer to sickness and intention respectively, the character *yi* is not part of everyday expressions. Among Chinese psychiatrists, nonetheless, *yi zheng* is a far more commonly used term than “dissociation” or “conversion,” a reflection perhaps of the fact that psychoanalysis has never been a dominant paradigm in Chinese psychiatry.<sup>36</sup> Conceivably, the total dismemberment of hysteria and its replacement by various dissociative disorders in the ICD-10 and DSM-IV have not appealed to the task force of the CCMD-2-R,<sup>37</sup> which retains both “hysteria” and “hysterical psychosis.” Positioning the latter “psychotic” condition under “neurotic mental disorders” is congruous with using etiology as a taxonomic strategy.

The second translation of hysteria is *xie si di li*, which is a phonetic rendering of the English (Greek) word. This is less often used clinically,

but may be employed by non-professionals to mean sudden uncontrolled excitement. Perhaps because of its semantic obscurity and phonetic clumsiness, the word *xie si di li de* ("hysterical") is less commonly used by lay people in China than in the West as a derisive label for the acute expression of emotionalism in women.

Among Chinese psychiatrists and lay people there is little sensitivity to Western feminist and social science critiques of the misuse of hysteria. This may reflect the fact that for political reasons, sociology, psychology and anthropology were banned by the Communist government in the 1950s and attacked as inadmissible examples of Western bourgeois influence during the 1966–1976 Cultural Revolution (Kleinman 1988).<sup>38</sup> As a result, social science paradigms for the critical analysis of mental health problems have been slow to develop. Not too surprisingly, *yi zheng* in China lacks the rich historiography that hysteria has engendered in the West (Micale 1995).

Few Chinese psychiatrists would contest that the diagnosis of hysteria has become less common in urban regions in recent years. The reasons for this are not entirely clear, but the same complex of factors which led to the delimitation of the hysteria concept in Western psychiatry do not seem to apply to the Chinese context. The de-Freudianization of psychiatric practice, for example, is hardly pertinent. According to Micale (1995), the second half of the century has brought four reconceptualizations of hysterical neurosis in the West: the Szaszian social-communicative critique, the Slaterian organic reinterpretation, the Anglo-American feminist rereading, and the Lacanian discursive and narratological model. These theoretical approaches are drastically dissimilar in their origins and aims but all of them take the form of "depathologizations" (p. 293). To the extent that these models have little direct impact on the interpretation and social course of *yi zheng* in China (Liu 1994), use of the label may continue for some time.

Although gender, urbanization, and literacy make a clear impact on the prevalence of hysteria in China (Liu 1994), there is at present no evidence to indicate that male doctors are more likely to use the diagnostic label than their female counterparts, or that female patients would judge the term and the doctors who use it to be paternalistic and insensitive. However, a feminist appraisal of Chinese patriarchy, institutional oppression, role conflict, and physical victimization (Striegel-Moore 1994) has not yet examined the clearly gendered aspects of *yi zheng*. By diversifying its loci of analysis, such an endeavour may ultimately bring beneficial tensions to bear on Chinese psychiatry.

The diagnosis of hysteria remains popular in rural China. For example, a series of 210 patients (female 168, male 42) so diagnosed according



to the CCMD-2 were recently reported from Anhui (Wang et al. 1995). As many as 170 and 118 of them were peasants and illiterate. Diagnosis was grounded in etiology, as clinical manifestations were diverse, including emotional instability, behavioural disturbance, personality change, paranoid symptoms, motor and sensory disturbance, hallucinations, sleep disturbance and mutism. Outcome was usually good. The authors did not mention sexual abuse, and attributed hysteria simply to "lack of education."

Ethnographic studies also conducted in rural China indicated that the situation is more complex, in that hysteria may arise from multiple sources of institutional oppression which breed high stress and low support in women. These include poverty, the kidnapping and selling of females as wives, imposed birth control and sterilization,<sup>39</sup> threats of divorce, and physical victimization by husbands who felt a loss of face after the birth of a baby girl. Hostile attitudes were also shown by their in-laws and neighbours, who shared the belief that since daughters would eventually "marry out," they were *pei qian huo* ("commodities on which the seller stands to lose"). In these circumstances, the diagnosis of hysteria may reflect the medicalization of routinised forms of social oppression of disempowered women who "refuse to suffer quietly" in rural China (Pearson 1995b; Zhou 1988).

Mass hysteria is also commonly reported among school children and female adolescents in rural China. A "bad suggestion" in a psychologically vulnerable population is believed to be the main etiological mechanism involved (Wu and Yu 1995). But not all categories of hysterical disorders are popular in China. Multiple personality disorder, which is said to be a dyadic disorder largely limited to the U.S.A. (Cooper 1995), is hardly ever diagnosed. Although the CCMD-2-R often excludes Western culture-specific disorders, the category is retained apparently because of the historical and theoretical interest it has aroused.

In contrast to their passion for hysteria and notwithstanding the widespread belief that Chinese people are particularly prone to somatization, Chinese psychiatrists are far from being impressed with the category of somatoform disorders. The main features of such conditions are the repeated presentation of physical symptoms and persistent requests for medical investigations despite negative findings and reassurances by doctors that the symptoms have no physical basis. The patient usually resists attempts to discuss the possibility of psychological causation even in the presence of precipitating psychosocial stressors (W.H.O. 1992: 161). With the exception of hypochondriacal neurosis (40.5), the whole block of somatoform disorders in the ICD-10 (F45)<sup>40</sup> are excluded in the CCMD-2-R.

Tyrer (1989) noted that "the introduction of the term somatoform disorders has been an American initiative, and the ICD-10 has been, somewhat reluctantly, carried in its wake" (p. 92). Grounded in the quintessentially Western intellectual legacy of mind-body dichotomy, the hybrid (half Greek and half Latin) word "somatoform" is simply neologistic to Chinese psychiatrists. Xu (1994) branded the concept of "somatoform disorder" as misleading. In his view, if patients have only somatic symptoms without mental or behavioural problems, then they should never be classified in Chapter V of the ICD-10. He also contended that the vast agrarian and poorly educated populations in China simply do not have the concept of functional versus organic mental disorders, and are often not concerned about the diagnoses made by doctors. As medical investigations are often unavailable, they would hardly exhibit "persistent requests for medical investigations" (W.H.O. 1992: 161).

As for urbanized Chinese people, Xu reckoned that they readily reveal emotional symptoms and acknowledge psychogenesis in the context of a sound doctor-patient relationship, suggesting that their bodily distress and psychic suffering are integrated and context-specific. He recommended that somatoform disorders are better subsumed under hypochondriasis, anxiety and depressive disorders. He also felt that the ICD-10 has unwisely borrowed the term from the DSM-III-R, and remonstrated that its widespread use in China may lead to inappropriate diagnosis and treatment. Jia (1995) similarly described the concept of somatoform disorder as obscure, misleading and unacceptable.

Support for Xu's thesis came from recent studies of patients with a CCMD-2-R diagnosis of neurasthenia in Hong Kong, Taiwan and China. Most of them were re-diagnosable as undifferentiated somatoform disorder or somatoform pain disorder according to the ICD-10 or the DSM-IV. But by focusing exclusively on somatic complaints, these categories did violence to patients' variegated symptom profiles and their elaboration in a network of psychosocial adversities. Their experience-distancing nature is self-evident when, say, undifferentiated somatoform disorder is translated as *wei fen hua qu ti zhangai*, which is unidiomatic and barely intelligible to Chinese people (Lee 1994).<sup>41</sup> Criticisms of the concept of somatoform disorders have also been raised by Western researchers such as Tyrer (1989), who concluded that the nomenclature for neurotic disorders "should have a longer lifespan in clinical consciousness than some of the names that have been generated frenetically in the past ten years" (p. 164). The same concept is not welcomed by Japanese psychiatrists either (see Yamashita and Koyama 1994).

Although neurasthenia has been expunged from the DSM-IV, it is retained under "other neurotic disorders" in the ICD-10 as it is "still regularly and widely used in a number of countries" (p. 15). Cooper (1995) too indicated that the ICD-10 differs from the DSM-IV by including neurasthenia, and by defining it "as simply as possible whatever the difficulties." However, Lee (1994) has clarified in an anthropologically sensitive essay that the ICD-10 definition of neurasthenia, which requires fatigue (or weakness) as the mandatory core symptom, misrepresents the illness reality of Chinese neurasthenic patients. In Hong Kong, insomnia and headache are usually the "core" symptoms of neurasthenic patients, while fatigue is commonly an accessory symptom. So the CCMD-2-R configuration of neurasthenia, in which any three out of five non-hierarchical groups of weakness, dysphoria, excitement, nervous pain and sleep symptoms constitute the diagnosis, is more congruous with the sinicized version of neurasthenia. It also eliminates the nosological need for somatoform disorders.

Not all Western researchers may be aware that the Chinese concept of neurasthenia has been substantially refurbished according to Western epistemological assumptions. It used to head the list of neurotic disorders in the early CCMD system, where mood and anxiety disorders were not exclusion criteria. In 1985 it became the fifth of seven types of neuroses, after anxiety neurosis, hysteria, phobia and depressive neurosis (Chinese Society of Neurology and Psychiatry 1979, 1982 and 1985). Dismemberment and marginalization of the category appear complete in the CCMD-2 and CCMD-2-R, where it becomes the seventh and the last type of neurosis, which should not be diagnosed if mood or other neurotic disorders are present. Clinical and epidemiological evidence has affirmed a disquieting plunge of neurasthenia in China (Lee 1994).<sup>42</sup> So although Good (1993) proposed that it can fruitfully be revisited as a form of comorbidity, its hierarchized definition may render this much less meaningful.

Besides somatoform disorder, neurasthenia is likely to overlap with "mixed anxiety depressive disorder," which is found as a residual category without specific criteria in the ICD-10 (p. 141). This is found to be common among Western patients in primary care, and has recently been recommended for inclusion in the future DSM system (Zinbarg et al. 1994). The proposed diagnostic criteria are reminiscent of *shenjing shuairuo*, except that their symptoms are hierarchically configured as the accompanying features of "dysphoric mood." The nature of dysphoria is not specified but depressive and anxiety disorders, as in the CCMD-2-R diagnosis of neurasthenia, are exclusion criteria. I have argued that several reasons should make the category a less cogent term to use than *shenjing shuairuo*.

in Chinese society. For example, if anxiety or depression is not patients' modal form of distress, it is ironic that their affliction should be labelled mixed anxiety-depressive disorder. Seen from this perspective, there is good justification for Chinese nosologists to resuscitate, not entomb, *shen-jing shuairuo* (see Lee et al. 1995).

Consonant with an etiologically based classification, depressive neurosis (or dysthymia) is grouped under neurosis rather than mood disorders in the CCMD-2-R. However, the academic pressure to relocate it is clearly growing, and has motivated a number of recent studies which were fashioned in such a way as to affirm the international nosological stance. For example, Tao and coworkers (1994) compared the symptoms, treatment response and psychosocial etiology of thirty three patients with depressive neurosis with those of fifty one patients with depression. By highlighting their similarity, they recommended that depressive neurosis should logically be grouped under "mood disorders." In another comparative study of the symptomatology, treatment response and outcome of 23 and 47 patients with CCMD-2-R depressive neurosis and depression respectively, Chen and Xu (1995) likewise found that, apart from a longer duration of illness of the former, the two groups were remarkably similar.

But dysthymia has been termed "a new plastic box for some rather old wine" (Goldberg and Bridges 1990), and "a technical euphemism for unhappiness" (Kleinman 1998). It represents a highly heterogeneous group of conditions that are frequently associated with intractable interpersonal difficulties and social misfortunes. Technically, Tyrer (1989) noted that it is a hard task to recall mood accurately over the previous two years, and emphasized that the condition overlaps with anxiety and personality disorders. When applied in many parts of the world, dysthymia may be an instance of the medicalization of politically and socially created conditions of chronic deprivation and persistent loss, which create powerlessness as a predictable corollary of an oppressive social system (Kleinman 1988). Reconceptualizing it as a "subaffective" variant of major depressive disorder (The WPA Dysthymia Working Group 1995) may therefore run the risk of encouraging health professionals to replace non-pharmacological ways of relieving chronic social distress with an excessive reliance on pharmacotherapy. Jia (1995) contended that to equate depressive neurosis with depression is to overlook its quintessentially "neurotic" nature.<sup>43</sup>

The nosological position of dysthymia is also economic in nature. From the vantage point of reimbursement, treating all depressive disorders as a pharmaco-responsive biological pathology may be guided by concerns over the high cost of psychotherapy in insurance-driven and patient-centered systems of health care. Given the huge clinical population

and the emerging influence of the pharmaceutical industry in China, there will be a powerful incentive to reclassify depressive neurosis under mood disorders in the future.<sup>44</sup>

#### CULTURE-RELATED MENTAL DISORDERS (41.2)

Culture-bound syndromes have often been cited in the argument against an international classification of mental disorders (Kirmayer 1991). Although the DSM-IV includes a glossary of 25 "culture-bound syndromes" (pp. 844–849), both the ICD-10 and DSM-IV do not include a diagnostic section of these conditions. By contrast, the CCMD-2-R creatively ventures beyond its Western counterparts to include three "culture-related mental disorders" under "neurosis and psychogenic mental disorders (40–41)." They include *koro*, *qigong* induced mental disorder, and superstition and witchcraft induced mental disorder (Table III).

*Koro* has continued to be the Chinese "culture-bound syndrome" most commonly reviewed by Western scholars (e.g., Draguns 1996).<sup>45</sup> But apart from occasional epidemics previously seen in Guangdong and Hainan Provinces, *koro* is now a very rare clinical condition<sup>46</sup> (Mao and Wang 1992; Xu et al. 1993), and may occur outside of Chinese society. *Qigong* induced mental disorder and superstition and witchcraft induced mental disorder are much less familiar to Western psychiatrists but are far more common clinical conditions than *koro* nowadays. Ethnographic work is lacking.<sup>47</sup>

*Qigong* ("exercise of vital energy") is a trance-based form of Chinese healing system which consists of meditational and/or diverse styles of movement exercise, induced by using a highly culture-syntonic set of suggestions based on the concept of *qi* (vital energy). Related activities are described in the most ancient Chinese medical textbook known as *Huangdi Nei Jing* (Yellow Emperor's Classic of Internal Medicine), but are infrequently mentioned in literature outside of China. Being intimately related to Taoist practices, *qigong* is believed to preserve health and prolong life (*yang sheng*), and to lead to moral self-cultivation. Revival of interest in *qigong* started in the early 1980s, when Chinese people were recovering from the social chaos and personal tragedy brought about by the Cultural Revolution, and many were busy with societal rebuilding. It has been estimated that not less than 5% of people in China practise *qigong*. Its popularity once amounted to a "fever" (*qigong re*), but has declined somewhat since the late 1980s (Ots 1994).<sup>48</sup> While this reflects a collective health consciousness, *qigong* is not completely innocuous.

Studies of *qigong* induced mental disorders have recently increased in China (Wu 1992 and 1993), in certain parts of which special clinics have been created for dealing with them (Chan et al. 1987). Because of their distinctive *qi*-related manifestations, these conditions have aroused diagnostic interest among Chinese psychiatrists themselves. The fact that *qigong* is part of traditional Chinese medicine and thus part of China's cultural heritage further motivates Chinese nosologists to highlight them as culture-specific mental disorders.

Locally, *qigong* induced health disturbances or *pian cha* are believed to arise from the inappropriate application of *qigong* and/or the inability to "terminate the *qigong*" (*shougong*). When severe, they are known as *zou* ("run") *huo* ("fire") *ru* ("enter") *mo* ("devil"), which means that the flow of *qi* deviates from the *jing luo* conduits and becomes "fire," as a result of which a devil intrudes into the person (metaphorically, referring etically to the emergence of psychotic symptoms). The condition violates the paradigms of quietness, relaxation and internal harmony which are followed in *qigong* practice. It may be corrected by a *qigong* instructor, but those who need to consult psychiatrists probably suffer from more severe forms of *qigong* related complications.

Diagnostically, a proportion of affected subjects may be placed in the ICD-10 category of unspecified dissociative disorder (F44.9) (Zheng et al. 1994), but this label lacks descriptive and explanatory power, and does violence to the emic complexity of patients' illness experience. Clinically, a variety of symptoms can occur, including *qi*-related somatic discomforts,<sup>49</sup> uncontrolled motor activity, anxiety, fright, weepiness, irritability, delusions, identity disturbance, hallucinations, mania, depression, suicidal, bizarre and violent behaviour (Chan et al. 1987; Wang 1994; Young 1994). As these symptoms lie on a continuum of severity and do not fit into one coherent syndrome recognized in the ICD-10 or DSM-IV, the CCMD-2-R criteria are grounded exclusively in the presumed etiology and situated meanings of symptoms, the psychopathological "form" of which is extraneous. Because similar manifestations may occur voluntarily in people who use *qigong* for healing or quackery, exclusion criteria are added (Table III).

Chan and coworkers (1992) in Shanghai compared 22 cases of *qigong* induced mental disorders with predominantly hysterical manifestations with the same number of patients with hysteria secondary to psychosocial stressors. The former patients were more frequently male, with automatism, *qi*-related somatic discomfort, and delusions and hallucinations the contents of which were closely connected with *qigong* (e.g., the delusion of being a *qigong* instructor with supranormal power). The inconspicuousness of motives in the sufferers also argued against hysterical disorders. Another

TABLE III

CCMD-2-R diagnostic criteria for *koro*, *qigong* induced mental disorder and mental disorders related to superstition and witchcraft

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*Koro:*

1. Onset is acute, with obvious psychosocial precipitants.
2. Main manifestations consist of fears that death will result from the retraction of reproductive organ, breast or other body parts into the body. Preventive measures are often adopted, such as using a string to hold the retracting body part. It is accompanied by intense anxiety or phobic symptoms.

*Qigong induced mental disorder:*

1. It is directly caused by *qigong*.
2. Symptoms are closely related to what *qigong* magazines or instructors say. Normally, these phenomena only occur during the practice or termination of *qigong*, but in affected patients, they persist or recur out of their own control.
3. Any one of the following will exclude this disorder:
  - i. the behaviour is used as a means of treating one's own or others' diseases;
  - ii. the behaviour is used as a means of obtaining material gains or achieving other purposes;
  - iii. the behaviour can be voluntarily induced or terminated.
4. No other mental disorder can be diagnosed.

*Mental disorders related to superstition and witchcraft:*

1. The mental disorder is caused by superstition and witchcraft.
  2. Symptoms are closely related to superstition and witchcraft, and consist chiefly of identity disorder arising from perceived possession by gods and ghosts, fleeting hallucinations, illusions, delusions and confusional behaviours.
  3. Any one of the following will exclude this disorder:
    - i. the behaviour is used as a means of obtaining material gains or achieving other purposes;
    - ii. the behaviour can be voluntarily induced or terminated.
  4. No other mental disorder can be diagnosed.
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study of 76 patients revealed that they differed from schizophrenic patients by their age of onset, etiology, symptomatology, treatment response as well as prognosis (Wu 1992).

As *qigong* induced mental disorders are usually short-lasting (Chan et al. 1987; Huang et al. 1990; Wu 1992), most cases probably never come to medical attention. The exact proportion of people engaging in *qigong* and developing psychiatric complications remains unknown. But Prince (1988) noted that similar problems are much less frequently described in the meditational practices of other cultures. As acute psychosocial stressors

are often absent, predisposing factors such as the tendency for physically and psychologically ill subjects to practise *qigong* (Ots 1994) and even prodromal schizophrenia may be contributory. In orthodox psychopathological terms (Kirmayer 1991), *qigong* is both pathogenic and pathoplastic.

Psychiatric treatment of *qigong* induced mental disorders consists of short courses of tranquilizers and sometimes an indigenously devised form of "*qigong* correction therapy" (Chan et al. 1987). Follow-up studies revealed that relapse was an exception even in the absence of prophylactic medications (Chan et al. 1987 and 1992; Huang et al. 1990; Wu 1992 and 1993). In order not to experience *zouhuo rumo* again, recovered patients may readily cease practising or change to a more gentle form of *qigong*, showing that the local meanings of *qigong*, far from being epiphenomenal, may authorize social adjustments that shape their illness career.<sup>50</sup>

Although ethnographies including those of the body-self in *qigong* induced mental disorders and their ritual healing by *qigong* masters are sorely needed, available evidence suggests that the content of symptoms, their situated meanings, cultural dynamics, course, etiology, and symbols involved in healing do make them a culture-specific syndrome (Lee and Yu 1995). Being readily legitimized by clinicians as well as patients and their family members, this cultural category effectively links folk and professional models of illness. A separate nosological status is of practical usefulness (e.g., in conducting health education on the risks of practising *qigong*, or in forensic evaluation) as well as heuristic value for sociocultural exegesis. Being more inferential than empirical in nature, the CCMD-2-R criteria are legitimately open to amendment in the future.

Superstition and witchcraft induced mental disorders are mostly seen in rural China, where people maintain a strong orientation to traditional folk culture, and witch doctors (*wu yi*) may outnumber biomedical health workers and become significant providers of health care (Li and Li 1994).<sup>51</sup> Patients with other mental disorders including schizophrenia should, by definition, be excluded (Table III).

Luo and coworkers (1993) briefly reported two peasants who presented with transient psychosis. One male subject, who had just been treated by a witch doctor, was deluded that his cousin became a fox fairy and possessed him. He then killed her and ate her liver. Another subject had worked as a spiritual medium. One day after a ceremony she became deluded that she was the greatest of all Buddhists. She developed persecutory beliefs towards her neighbours and husband and became disturbing. After acute treatment, both patients remained well at two-year follow-up.

In a larger series of 35 patients, Hu and coworkers (1994) found that identity disturbance, auditory/visual hallucinations, delusions, affective



disturbance and confusional behaviour were the main clinical features. The illness lasted about two weeks, and its symptoms were closely related to particular superstitions and religious beliefs.<sup>52</sup> Affected subjects were mostly female (86%) with little education, and were "superstitious." They responded well to low doses of antipsychotic medication, and their prognosis was found to be considerably better than that of schizophrenic patients.

The relationship of both superstition, witchcraft and *qigong* induced mental disorders to the ICD-10 category of trance and possession disorders (F44.3) remains to be clarified.

#### PHYSIOLOGICAL DISORDERS RELATED TO PSYCHOLOGICAL FACTORS (50-59) (F50-F59)

Given the rarity of eating disorders in China,<sup>53</sup> it is not surprising that the CCMD-2-R criteria for anorexia nervosa closely follow the ICD-10 and DSM-IV. They require, among other features, the presence of an intense fear of fatness in the face of obvious emaciation. As recognised by a number of Western researchers themselves, the diagnostic construct of "fat phobia" may be unnecessarily ethnocentric, and is not as theoretically neutral as the DSM system may like to claim it to be (Steiger 1993). For example, it is frequently absent among Chinese anorectic patients, who may use other rationales (e.g., abdominal bloating, loss of appetite) for legitimating voluntary non-eating. Since the DSM-IV and ICD-10 diagnostic criteria for anorexia nervosa may amount to a category fallacy (Kleinman 1988) when applied in a Chinese setting, more culture-flexible diagnostic criteria which take account of the local meanings of food refusal will be adopted in the next version of the CCMD (see Lee 1995).<sup>54</sup>

Another point of cross-cultural interest pertains to the amount of weight loss. The CCMD-2-R requires a weight loss of 25% or more of standard body weight for a diagnosis of anorexia nervosa to be made. Given the generally slim body shape of Chinese females, this is a stringent requirement compared to that of the ICD-10 and DSM-IV, where a more lenient weight loss of 15% is required. It implies that mild forms of anorexia nervosa will be excluded.

I have proposed that the biomedical diagnosis of anorexia nervosa runs a social course. Briefly stated, the preeminent feature of the condition was emaciation several decades ago, when fat phobia was not a diagnostic construct. In the recent two decades, the weight threshold has been slackened at the same time as the diagnostic emphasis on fat phobia has been magnified. These changes, which facilitate the identification of mild forms

of anorexia nervosa, may arise from the need to invoke social censure on excessive dieting on the one hand, and the public's legitimation of weight reduction as a symbol of attractiveness on the other.<sup>55</sup> As serious dieting to pursue slimness and eating disorders are still rare in China, a lenient criterion of weight loss has not yet evolved (Lee 1996).

As in the ICD-10, the CCMD-2-R also allows the use of body mass index (BMI) in the evaluation of weight loss.<sup>56</sup> Among non-obese Western women, this has a range of 20–25 kg/m<sup>2</sup>. But the BMI of Chinese females is lower because of their smaller size (Lee 1993).<sup>57</sup> The simultaneous use of 25% weight loss and a BMI of <17.5 kg/m<sup>2</sup> in the CCMD-2-R is therefore inconsistent. Take a Chinese girl who weighs 50 kg and measures 1.63 m (BMI = 18.8 kg/m<sup>2</sup>) as an example. A 25% weight loss will mean that she has to weigh 37.5 kg or less (BMI ≤ 14.1 kg/m<sup>2</sup>) to receive a diagnosis of anorexia nervosa. By contrast, a BMI of <17.5 kg/m<sup>2</sup> will mean that she only needs to weigh 46.5 kg or less for the same diagnosis to be made. This weight difference of 9 kg is substantial, especially if her modest original size is considered. A 15–20% weight loss or a BMI of <16 kg/m<sup>2</sup> is desirable for the clinical diagnosis of anorexia nervosa in Chinese populations (Lee 1995).

#### PERSONALITY DISORDERS, IMPULSE DISORDERS, AND SEXUAL PERVERSION (60–62) (F60–F69)

The clustering of these three groups of conditions has an historical basis (Table I), as sexual perversion was considered a kind of psychopathic personality in early Russian classifications (Giljarovskij 1954, in Stengel 1959).

There are several ways of understanding personality disorders. Seen from a cultural constructionist perspective, they are based on Anglo-American conceptions of personhood and codes of appropriate behaviour, and owe their existence to the medicalization of disvalued social behaviour (Fabrega 1994b). Accordingly, transformations in a society's values will determine whether they are called disease, sin or crime. Nosologically, personality disorders tax the empiricist epistemology of the DSM system because the ascription of personality traits calls for inferences beyond the direct observation of phenomena (Millon 1991). Given the disparity between the Oriental and Occidental conceptions of personhood, queries over the contextual validity of personality disorders are to be expected.

Previously labelled pathological personality (*bingtai renge*) or personality perversion (*rengge biantai*), personality disorders (*rengge zhangai*) are neither common clinical diagnoses nor popular research topics in China.

Limited epidemiological studies reveal that their prevalence was considerably lower than that of the West (Cheung 1991). Published work is mainly about the criminological aspects of psychopathy (e.g., Qi et al. 1993). Zhu and Yao (1991) ascribed the clinical rarity of personality disorders to the fact that they were perceived as moral rather than medical problems in China. The previous lack of operational diagnostic criteria could have further discouraged their identification.

Few Chinese psychiatrists, though, would refute the existence of personality disorders. In a clinical study of 41 patients (male 27, female 14, mean age 27.3 years) seen over a period of sixteen years (1973–1989), Zhu and Yao (1991) in Nanjing found that apart from nine patients who might be classified as antisocial (3), paranoid (2), explosive (1), hysterical (1), dramatic (1) and borderline (1) types, 32 of them (78%) did not fall into distinct subtypes. Generally, antisocial behaviour and poor impulse control were prominent, while a childhood history of conduct disorder was common. The failure to classify was also noted in at least three other studies (Wu et al. 1995: 34%; Xie et al. 1992: 63%; Xu et al. 1993: 53%). For unclear reasons, treatment response was uniformly unsatisfactory.

Although a major volume entitled *The DSM-IV Personality Disorders* does not mention issues of cross-cultural validity at all (Livesley 1995), what a review of these limited data may suggest is that some categories of personality disorders lack contextual validity in Chinese society. Because Chinese psychiatrists are generally inexperienced in these diagnostic categories, they should be particularly cautious about importing the simple polythetic categorizations *en bloc*. In this respect, it may be reassuring to note that two of the eight types of personality disorders listed in the ICD-10 are excluded in the CCMD-2-R. They are anxious (avoidant) and dependent personality disorders (F60.6 and F60.7). This may be because many of their defining features are normative or tolerated in the Chinese culture.<sup>58</sup> They conform with the shame-oriented precepts of Confucianism, which defines personhood not by autonomy, voluntarism and assertiveness, but by intergenerational dependence, self-effacement, and social harmony (Hsu 1971). They usually cause neither personal distress nor interpersonal frictions, which are crucial characteristics of personality disorders. Similarly, borderline personality disorder is not found.

The category of pathological gambling (F63.0) is also absent in the CCMD-2-R. In Chinese society, gambling in moderation is ubiquitous. People who gamble immoderately and ruin their lives are considered bad rather than mad. So Chinese psychiatrists are diffident about medicalizing gambling. Expectedly, no report of pathological gambling is found in the Chinese literature. But a community epidemiological study in Hong

Kong revealed that pathological gambling was the third most common psychiatric disorder in adult males, after substance abuse (mostly nicotine) and generalized anxiety disorder (Chen et al. 1993). However, the condition rarely presents clinically, suggesting that its lay and professional conceptions are at variance with each other.<sup>59</sup>

What about sexual disorders? The ICD-9 stated that the definition of abnormal sexual behaviour in different cultures serves "approved social and biological purposes" (p. 40). Given that Chinese society is conservative and sexual education was until recently a prohibited topic, cultural variations in the CCMD-2-R are to be expected.

The somewhat pejorative heading of "sexual perversion" (*xing bian tai*) (Table II) is used to include disorders of sexual orientation, sexual preference, and gender identity. Of the ICD-10 gender identity disorders, transsexualism, but not dual-role transvestism (F64.1) and gender identity disorder of childhood (F64.2), is found. The whole ICD-10 block of "psychological and behavioural disorders associated with sexual development and orientation" (F66), which consists of novel entities such as "sexual maturation disorder, egodystonic sexual orientation, sexual relationship disorder", is excluded. As excessive sexual drive (F52.7) is considered culturally inappropriate, it is not included as a form of sexual dysfunction (Editorial Board of Journal of Clinical Psychological Medicine 1994). Paedophilia (F65.4), notwithstanding the publicity it has aroused in Western societies, is also excluded.

But exclusive homosexuality is retained as a diagnostic category. According to Young (1994), this is because there is a lack of either biological or psychological evidence to show that it is "absolutely normal", and that some homosexual people do seek medical or psychological help.<sup>60</sup>

However, Lau and Ng (1989) demonstrate that homosexuality not only has a long history but is also common in Chinese society. My own experience suggests that younger generations of Chinese psychiatrists may be more likely to consider homosexuality a legitimate variant of human sexuality. Some of them are also aware of how views towards homosexuality have evolved in the West (e.g., Hu 1995). It should be noted that even in the United States, where individual rights are considerably more emphasized than in China, the diagnostic category of "egodystonic homosexuality" was not deleted from the DSM system until quite recently (American Psychiatric Association 1987). It remains to be seen whether China's economic reforms which inevitably foster individualistic values and self-expression will lead to the maturation of the Chinese gay community and the depathologization of homosexuality.

Most kinds of sexual deviations, such as transsexualism, voyeurism, fetishism, transvestism and homosexuality, can be found in the Chinese psychiatric literature. For example, Fang (1994) in Beijing reported a series of forty transsexuals. Contrary to Western data, a higher female-to-male ratio (22/18) was found. Fang suggested that this could be due to some female subjects having been "brought up as if they were boys" in a patrilineal society which placed a high premium on having sons. Besides a significant rate of suicidal behaviour (85%), some subjects attempted self-surgery, such as by cutting off the penis (Liu et al. 1992). As sexual reassignment surgery was neither socially acceptable nor easily available, Fang urged that proper laws and treatment methods be devised.

Liu and coworkers (1995) drew attention to inconsistent judicial attitudes towards transsexuals' criminal responsibility, as similar offences in different provinces had received discrepant penalties, ranging from death to instant release. The high rate of suicidal behaviour found in nearly all clinical reports of homosexuals and transsexuals (Gao and Duan 1991; Fang 1994; Liu et al. 1992 and 1995) might reflect the intense psychological distress they experienced in a sexually restrained society.

#### MENTAL RETARDATION (70) (F70-F79)

Apart from the addition of a "borderline intelligence" category (IQ 70-84), this block is the same as the ICD-10.

#### MENTAL DISORDERS IN CHILDHOOD AND ADOLESCENCE (80-86) (F80-F89; F90-F98)

This part of the CCMD-2-R classification is a condensed version of the ICD-10 or DSM-IV. It reflects the fact that child psychiatry is still a very underdeveloped subspecialty in most parts of China, where it was historically limited to mental retardation and hyperactivity (Chen 1995). Because complex classifications are believed to be perplexing to Chinese psychiatrists, subtypes (e.g., of hyperkinetic disorder and conduct disorder) and novel categories (e.g., oppositional defiant disorder, reactive/disinhibited attachment disorder of childhood) are deleted. The ICD-10 category of sibling rivalry disorder (F93.3) is not included, apparently because of the one-child-per-couple family plan enforced in China since 1980. Rather, an unsubstantiated fear exists that overindulging the only child and juvenile delinquency will become social problems (Chen 1995).

Although published work on childhood psychiatric disorders is limited, the clinical pattern of morbidity in China appears to differ from that of

developed countries. In an analysis of 456 children who attended a children's mental health clinic in the urbanized city of Shenzhen, emotional (3.3%) and conduct (2.2%) disorders, which form the bulk of childhood psychiatric disorders in the West, constituted only 5.5% of the cases (Yu 1993). Hyperactivity (17.3%), speech disorders (12.9%), mental retardation (12.5%), and sleep disorders (5.3%) made up the majority. At this stage it is unclear if this clinical pattern arose from Chinese socialization practices, or from different thresholds for symptom recognition and help-seeking. The high priority that parents and teachers place on docility should almost assuredly sensitize them toward identifying hyperactive children as being problematic.

Compared to Western countries, there is a notable lack of public knowledge and professional awareness about childhood autism. Although Wu (1992) estimated that there are half a million autistic children in China, the condition has started to draw clinical and public attention only recently. Help-seeking is often delayed (Tong and Yu 1994). The explicit diagnostic criteria in the CCMD-2-R will enable more autistic children to be identified.

What with modernization and the heightened parental attention given to single children, the practice of child psychiatry is expected to develop more rapidly in the years to come.

#### OTHER MENTAL DISORDERS, FORENSIC CONDITIONS AND CONDITIONS RELATED TO MENTAL HEALTH (90-99) (F99)

This section is particularly relevant to forensic evaluations (see Jia 1995).

#### CONCLUSION

Inasmuch as the subject matter of psychopathology is inherently diverse and imprecise, its classification is logically arbitrary and prone to social influence (Millon 1991). As social constructs, psychiatric disease categories have social uses peculiar to the social groups in which they are devised and legitimized. For example, the DSM schema is so organized that every conceivable psychiatric condition is listed as a disease to legitimate remuneration to practitioners from private medical insurance and government programs (Kleinman 1988); this intended consequence may be quite irrelevant to non-American countries. Therefore, although the DSM schema has now been used worldwide, Cooper (1995) rightly cautioned that "even in the United States there may be some ambivalence about

DSM-IV, so those of us in other countries need to evaluate it with special care.”

Overall, it appears that there are more similarities than differences between the CCMD-2-R and the ICD-10. Xu T.Y. (1994) contended that the CCMD-2-R is redundant because the “others” categories should allow all mental disorders in China to be classified within the ICD-10. From this compartmentalistic perspective, it is possible that further blending of the two schemes will allow the ICD system to be fully adopted in China.<sup>61</sup>

Should that be the goal of Chinese psychiatrists? Fabrega (1994a) highlighted several crucial ways in which culture and social processes limit the establishment of an internationally valid system of diagnosis in psychiatry. Likewise, Stengel (1959) as well as Sartorius (1988) reiterated that an international classification must not aim to oust or replace regional classifications which often have valuable functions in the local contexts in which they are devised. No single classificatory system, Kirmayer (1991) submits, will suffice for all purposes – the “correct” diagnostic scheme is the one that accomplishes its explicit pragmatic aim by addressing the relevant level of description.

In the CCMD-2-R, the particular additions (e.g., travelling psychosis, culture-related mental disorders), deletions (e.g., somatoform disorders, pathological gambling, a number of personality and sexual disorders), retentions (e.g., unipolar mania, neurosis, hysteria, homosexuality), and epistemological variations (e.g., depressive neurosis, neurasthenia) of diagnostic categories are a reflection of the changing notions and reality of illness in contemporary China. Being grounded in decades of clinical experience accrued by Chinese psychiatrists, it is significantly more acclimated to the indigenous Chinese context than the ICD-10. Nonetheless, since frequent and arbitrary changes in nosology may create ambivalence and cynicism (Stengel 1959; Zimmerman 1988), Chinese psychiatrists need to move the nosological debates into the domain of empirical investigations that encompass an anthropological understanding of validity. In this respect the social science paradigms have much to offer by pressing for a more theoretically sophisticated and conceptually critical approach to Chinese psychiatry (Kleinman 1988).

The CCMD-2-R is a critique of certain abiding assumptions of Western psychiatry and its unresolved nosological quandaries, such as the feasibility of a neo-Kraepelinian taxonomy grounded exclusively in symptomatology across all diagnostic categories,<sup>62</sup> and the cultural validity of syndromic architectures and diagnostic constructs derived from an adamant adherence to the mind-body dichotomy (Good 1993; Kleinman 1988; Lee 1994; Sartorius 1988; Stengel 1959). Regarding the eradication of terms such

as neurosis and hysteria, Cooper (1995) questioned the capriciousness of American psychiatry, and alerted authors of the DSM-IV that they should remember the warning given by Sir Aubrey Lewis about the tendency of some psychiatric terms to outlive their obituarists.

Likewise, Young (1994) admonished that terminological change is not equivalent to scientific progress and, before substantial additions to knowledge have accrued, little may be gained by merely changing diagnosis from one category to another, or by artificially eliminating all epistemological indeterminacies. To the extent that Chinese psychiatry has been committed to a biological paradigm of psychopathology and familiar forms of psychotherapies have only started to develop in China (Chen 1995), the retention of terms such as neurosis, hysteria, and culture-related mental disorders, which instantly invoke psychogenesis, will help Chinese psychiatry develop as per a biopsychosocial paradigm. All in all, there are legitimate arguments for the continuance of a national psychiatric classification in China, especially if crosswalks are available for efficiently converting it into the international system. Given the interpenetration of different psychiatric classifications rendered possible by enhanced international communication, the CCMD-2-R should usefully contrast with the ICD-10 and DSM-IV as the move towards an international nosology continues.

While the CCMD-2-R should provide a common language for communication, standardize discrepant diagnostic practice, facilitate research<sup>63</sup> and boost the professional pride of psychiatrists in China, its impact on everyday clinical work and psychiatric training remains to be evaluated. A risk exists that the obsessive pursuit of reliability and catechetical compliance with congealed definitions may obscure their arbitrariness and overtechnologize patients' illness experience, especially in settings where neophyte psychiatrists are deprived of personal supervision by experienced clinicians. Through routinisation, operationalized criteria may predispose clinicians to exaggerating etically defined similarities and creating closure of emic peculiarities.<sup>64</sup> From the perspective of cross-cultural research, they may needlessly remove conditions that are only superficially different from the original defining condition (Kleinman 1988). An important message is that diagnostic categories are optional tools which should guide, but not direct, the observation and interpretation of the natural world (Millon 1991).<sup>65</sup>

Sartorius (1988) considered that a classification is a way of seeing the world at a point in time. Seen from this perspective, the CCMD-2-R is a practical avenue for achieving an understanding of the Chinese mind as well as the social realities in China. On the macrosocial level, for example, its successful publication points to the greater institutional



autonomy and power of professional psychiatry in a country which had previously severed all her ties with the non-Communist countries of the Western world, and which has gone through drastic economic, political and institutional transformations that make it a clearly different place from what it was in the not so distant Maoist past (Kleinman 1988). These social realities have assuredly contributed to the development of a diagnostic system that is more rigorous, more synchronized with international models, and distinguished by a greater degree of specificity as well as contestation. The CCMD-2-R and the scientism it issues may in turn help establish psychiatry, which is still considered second class medicine for postgraduate training, as a more respectable division of medicine in China.

The remarkable hybridity of China at present, namely, a Communist Party dominated state socialist political structure but the most rapidly growing capitalist economy in the world, promises that Chinese people's notions of health and patterns of sickness, and thereby the dialectic between categories and experience, will continue to change. With its increasing openness, rich regional and ethnic diversities, China furnishes a fascinating testing ground for nosological systems and sociosomatic processes. I hope this preliminary paper will provide impetus for more studies in the future.

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*Department of Psychiatry  
The Chinese University of Hong Kong  
Prince of Wales Hospital  
Shatin, Hong Kong*

#### NOTES

1. As Stengel (1959) remarked, "a history of psychiatric classification would be almost tantamount to a history of psychiatry."
2. This perspective does not negate the role of deranged physiology in psychiatric disease categories, of course.
3. A similar revival of interest in nosology took place in American psychiatry in the 1970s (See Good 1993 and Klerman 1988).
4. The ICD-10 has an internationalized nature, and was available to Chinese psychiatrists earlier than the DSM-IV. Twelve Chinese psychiatrists were principal investigators in its field trials (W.H.O. 1992, p. 313).

5. The ICD-10 is a comprehensive classification of physical diseases, mental disorders and related health problems.
6. Stengel (1959) noted that the best classification cannot serve its function unless clinicians want to use it. Although Sartorius (1988) suggested that one main requirement for an international classification of mental disorders is that "it must take into account languages into or from which the classification will be translated" (p. 12), numerous translational difficulties which may hamper clinical communication have been identified in the Chinese ICD-10. The choice between linguistic and conceptual equivalence is one major source of dissension (see Jia 1995 and Xu 1995).
7. It may be simplistic to say that the DSM-IV is exclusively based on symptomatology, since etiological factors are implied, and sometimes emphasized, in a number of conditions, e.g., post-traumatic stress disorder, anorexia nervosa, conversion disorder, and bereavement. As Stengel (1959) advised, "no psychiatric classification can help being partly etiological and partly symptomatological, because these are the criteria by which psychiatrists distinguish mental disorders from each other" (p. 619). The question is one of degree.
8. These "crosswalks" are not only due to the fact that the Ministry of Health in China has continued to use the ICD-9 for coding official statistics, but are also to facilitate rapprochement between the CCMD-2-R and ICD-10.
9. The phonetic transcription of Chinese characters.
10. Alphanumeric codes which start with "F" in this paper refer to ICD-10 codes, while numeric codes indicate CCMD-2-R codes.
11. The Chinese Society of Neurology and Psychiatry were formally split into the Chinese Society of Neurology and Chinese Society of Psychiatry in 1994. From January, 1996 onwards, the latter publishes its own academic journal, which contains longer English abstracts, and is no longer dominated by neurological articles.
12. These include formal thought disorder, delusions, incongruous affect, auditory hallucinations, motor abnormality, avolition, passivity experiences, and thought insertion or withdrawal.
13. This does not apply to simple schizophrenia which should last two years or more.
14. In Hong Kong, although psychiatric trainees who sit the Membership Examination of the Royal College of Psychiatrists (U.K.) have been advised to use the ICD-10, most of them will not label acute psychotic patients as having schizophrenia. Less stigmatizing labels such as "acute psychosis" are used.
15. Jia (1995) emphasized the usefulness of this category in the assessment of criminal responsibility.
16. This is the provincial capital of Xinjiang, a province in the northwestern part of China.
17. During cold weather, closed windows would further impair air circulation.
18. These conditions for travel may be hard for people outside of China to imagine. For example, several people may be crammed into a small toilet built for one person, while others stuff themselves on luggage rails, or under seats. They may suffer from difficulty in breathing, and avoid drinking because there is no toilet.
19. E.g., from Sichuan, Xian, Zhengzhou, Beijing and Shanghai to Wulu Muqi.
20. If confirmed, dehydration is a clearly correctible cause.
21. Since multiparity was normative in traditional Chinese society, women were either pregnant or on maternity care during a significant portion of their reproductive life. As a result, little time was left for them to experience premenstrual distress. It is plausible that the increased social status and greatly reduced fertility of women in urban China

- will supply the social context in which premenstrual syndrome is legitimized as an idiom of distress and a biomedical entity.
22. In the CCMD-2-R depression may be specified as "mild type" (*qing xing yi yu zheng*), but this is uncommonly used. That dysthymia is sometimes translated like this (e.g., Young 1994) would therefore confound the ICD-10 and DSM-IV nomenclature.
  23. The term is synonymous with, but much more commonly used, than dysthymia (*xin jin e lie*).
  24. Clinically, these subtypes are extremely difficult to discern. As Tyrer (1989) noted, their classification is "really a dimensional one in a categorical disguise" (p. 73).
  25. As in the ICD-10, the word "major" does not appear in the CCMD designation of depression.
  26. In Hong Kong, a similar misreading arises among psychiatric trainees and medical students, who think that a patient with "major" depression must suffer severely and require standard pharmacotherapy. Conceptually, they find it hard to accept that a "major" depression can nonetheless be "mild" in severity.
  27. Major depression is not divided into mild, moderate and severe types in the DSM-III.
  28. Support for my suspicion may be found in a special issue of *Culture, Medicine and Psychiatry*, in which a paper originally written by Yan (1989) about neurasthenia was translated into English for publication. Ostensibly, Yan had referred to major depression as *zhong xing yi yu zheng*, because in the published English version of the paper, major depression was designated "severe depression" (p. 142) instead. Obviously, not all eighty seven patients Kleinman studied were severely depressed.
  29. Although comorbidity was common in the neurasthenic patients Kleinman studied, the DSM-III excluded anxiety disorders when major depression was present. This encouraged readers to comprehend neurasthenia simply as a Chinese form of major depression (Good 1993).
  30. If Kleinman's study shocked Chinese psychiatrists into over-constraining the broad ambit of *shenjing shuairuo* and into popularising depression as a diagnosis, the Chinese experience also shocked him into accepting *shenjing shuairuo*, which simultaneously recognizes the cognitive, emotional and somatic dimensions of human suffering, as a category of disorder every bit as valid as the items in the somatoform disorders category of the DSM-III-R and DSM-IV (Kleinman 1986: 162 and personal communication 1995).
  31. All three symptoms are required for a diagnosis of severe depression.
  32. The question of why depression in the absence of a depressed mood should be called depression is political and epistemological, not empirical, in nature.
  33. For example, Kleinman (1982) found that all the neurasthenic patients he interviewed presented with "non-specific" forms of dysphoria, but a spontaneously presented "depressed mood" was an exception (p. 148). Evidently, Kleinman had not relied on an expressed depressed mood for making DSM-III diagnoses.
  34. In the ICD-10, F40-F48 consists of "Neurotic, stress-related and somatoform disorders", so the word neurosis does not really exist.
  35. Teaching and provincial hospitals in China may devote a ward specifically to the care of patients with neurosis.
  36. The Chinese translations of dissociation and conversion as *fen li* and *zhuan huan* are also awkward to use.
  37. Young (1993b) as well as Jia (1995) metaphorically described the replacement of hysteria by dissociative disorders in the DSM-IV as *zhi jie*, which refers to an ancient form of cruel punishment in which a person's limbs were chopped away.

38. This may partly explain the subsequent development of a predominantly medical and potentially less reflexive model of psychiatric practice in China. During the Cultural Revolution, mental illness was attributed by the ultraleftists to wrong political ideology that could be reformed.
39. Rural males are much less willing than urban males to accept sterilization in China, as they believe that the procedure may adversely affect their needed physical strength, in addition to effecting infertility.
40. These include somatization disorder, undifferentiated somatoform disorder, hypochondriacal disorder, somatoform autonomic dysfunction, persistent somatoform pain disorder, and other somatoform disorders. Somatization disorder is surprisingly rare in Chinese society (Chen et al. 1993; Gao and Liu 1992).
41. Sartorius (1988) recommended that an international classification of mental disorders must take into account languages into which the classification will be translated (p. 12).
42. It is, however, unlikely that neurasthenia will be eradicated from Chinese nosology. It is still a commonly used diagnostic category in non-psychiatric medical settings in China.
43. Depressive neurosis remains a type of neurotic disorder in Japan too (Yamashita and Koyama 1994).
44. Although their efficacy is typically wide-ranging, psychotropic drugs are usually given specific labels (e.g., antidepressant, anti-anxiety, anti-obsessional, and anti-panic agents) which reify, rather than validate, the corresponding disease categories and foster the neo-Kraepelinian reorientation of Western psychiatry. New generations of antidepressants are already in use in China.
45. The CCMD-2-R designation of *koro* as *kong suo zheng* ("syndrome of panic over retraction") is broader than its description as *suo yang zheng* (penile retraction syndrome) in the English (e.g., W.H.O. 1992, p. 179) and previous Chinese literature, in that both genital and non-genital protruding organs (e.g., nipples, nose, ears, tongue) may be retracted.
46. Epidemics of *koro* used to occur in the Southern parts of China (e.g., Hainan Island) where improved living conditions and higher levels of education have contributed to their marked decline.
47. A possible exception is an ethnographic study of *qigong* in China provided by Thomas Ots (1994).
48. There are probably more *qigong* journals in China than hypnosis journals in the U.S.
49. Typically, "stagnation" of *qi*, or *qi* "scurrying in abnormal directions in the body".
50. Ots (1994) interpreted the recent delegitimation of the more cathartic forms of *qigong*, which result in screaming and marked spontaneous movements (*zi fa gong*), as the political silencing of free expression in China (p. 130). Nonetheless, the possibility is accepted by Chinese psychiatrists that these forms of *qigong* are more likely to induce mental disorders (Prince 1988).
51. See a series of ten articles about witch doctors in volume 6 (Supplement 1) of the Medical Journal of Chinese Civil Administration, 1994, published by the Chinese Society of Civil and Rehabilitative Medicine (in Chinese).
52. They were related to Chinese and Buddhist gods as well as Christianity.
53. Eating and sexual disorders were not included in previous epidemiological studies in China (Cheung 1991).
54. Personal communication with Y.F. Chen, Chairman of the CCMD-3 Task Force.
55. The political and economic forces which maintain a powerful "keep-fit" industry in the West have not yet developed in China.

56. BMI reflects overall body shape and is computed by the formula "body weight in kg/height in m<sup>2</sup>". Chinese psychiatrists are not yet familiar with using this concept.
57. In this study, the median BMI of female undergraduates in Hong Kong was 19.3 kg/m<sup>2</sup>, which was "subnormal" by Western standard. Moreover, the BMI of 15% of them was <17.5 kg/m<sup>2</sup>, which is the ICD-10 diagnostic threshold for anorexia nervosa. Other data showed that these constitutionally slim females aspired to gain weight.
58. The diagnostic features of avoidant personality disorders include, among others, "belief that one is socially inept", "excessive preoccupation with being criticized or rejected in social situations", and "unwillingness to become involved with people unless certain of being liked". Those of dependent personality disorders consist of "allowing others to make most of one's important life decisions", "subordination of one's own needs to those of others on whom one is dependent", "feeling uncomfortable when alone, because of exaggerated fears of inability to care for oneself", and "limited capacity to make everyday decisions without an excessive amount of advice and reassurance from others".
59. In Hong Kong, public ambivalence towards gambling may be reflected by the fact that, depending on whether they win or lose substantially, people who gamble a great deal may be termed "gods of gambling" (*du sheng*) or "addicts of gambling" (*du gui*). A number of movies entitled *du sheng* became big box office hits.
60. Historically, the ICD-9 describes "sexual deviations and disorders" as "abnormal sexual inclinations or behaviour which are part of a referral problem" (WHO, 1978, p. 40), and includes homosexuality (302.0) as a diagnostic category. In this case, help seeking may, of course, be socially induced.
61. The ICD-10 has been adapted for local use in a number of countries (e.g., Kitamura 1994; Otero-Ojeda 1994). Whether it will replace the DSM approach which has been more influential in China over the last decade remains to be seen.
62. I concur with Kirmayer (1991) and Kleinman (1988) that psychiatric diagnoses are not things and may never be related to distinctive pathophysiological processes. Biological correlates and methods of treatment may be found, of course.
63. Computerized diagnostic instruments which generate CCMD-2-R, ICD-10 and DSM-IV diagnoses have been developed in China (Chen 1994; Zheng et al. 1994).
64. Some Chinese psychiatrists have shown an interest in the multi-axial systems of diagnosis (e.g., Chen 1994), which may help offset the disadvantages of diagnostic pigeon-holing, and promote contextual formulations.
65. The question of how perfecting the reliability of psychiatric diagnosis may profit psychiatric training or clinical care is rarely examined critically.

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APPENDIX: CHINESE CLASSIFICATION OF MENTAL DISORDERS, 2ND EDITION REVISED (CCMD-2-R)<sup>1</sup>

- 0 Mental disorders due to organic brain disorders and physical diseases (F00-F09)**
- 00 Mental disorders due to organic brain disorders (F00-F09)
- 00.0 Alzheimer's disease
- 00.00 Alzheimer's disease, presenile type
- 00.01 Alzheimer's disease, senile type
- 00.02 Alzheimer's disease, atypical or mixed type
- 00.08 Alzheimer's disease, other types
- 00.1 Mental disorders due to cerebrovascular diseases
- 00.10 Mental disorders due to acute cerebrovascular diseases
- 00.11 Multi-infarct dementia
- 00.12 Mental disorders due to subcortical vascular diseases
- 00.13 Mental disorders due to mixed cortical and subcortical vascular diseases
- 00.18 Mental disorders due to other cerebrovascular diseases
- 00.2 Mental disorders due to other cerebral degenerative diseases
- 00.20 Pick's disease
- 00.21 Mental disorders due to Parkinson's disease
- 00.22 Mental disorders due to Huntington's disease
- 00.23 Mental disorders due to hepatolenticular degeneration (Wilson's disease)
- 00.28 Mental disorders due to other cerebral degenerative diseases not including the above items (i.e., 00.20-00.23)
- 00.29 Mental disorders due to unspecified cerebral degenerative diseases
- 00.3 Mental disorders due to intracranial infections
- 00.3 Mental disorders due to Creutzfeldt-Jacob's disease
- 00.3 Mental disorders due to post-encephalitic syndrome
- 00.4 Mental disorders due to brain injury
- 00.46 Postconcussional syndrome
- 00.5 Mental disorders due to intracranial tumour
- 00.6 Mental disorders due to epilepsy
- 00.8 Mental disorders due to other organic brain disorders
- 01 Mental disorders due to physical diseases
- 01.0 Mental disorders due to bodily infections
- 01.1 Mental disorders due to visceral diseases
- 01.2 Mental disorders due to endocrine diseases

<sup>1</sup> Diagnostic criteria are omitted.

- 01.3 Mental disorders due to nutritional and metabolic diseases
- 01.4 Mental disorders due to chromosomal abnormalities
- 01.5 Mental disorders due to diseases caused by physical factors
- 01.8 Mental disorders due to other physical diseases
- 01.9 Mental disorders due to unspecified physical diseases

A fourth digit code in 00.3–00.8 and 01 indicates:

- 0X.X0 impairment of intelligence
- 0X.X1 amnesic syndrome
- 0X.X2 disturbance of consciousness
- 0X.X3 personality change
- 0X.X4 psychotic symptoms
- 0X.X5 affective disorder
- 0X.X6 neurotic symptoms
- 0X.X8 other mental symptoms
- 0X.X9 Unspecified mental symptoms

## **1 Mental disorders due to psychoactive and non-dependent substance use (F10–F19)**

- 10 Mental disorders due to psychoactive substance use (F10-F19)
  - 10.0 Mental disorders due to alcohol
    - 10.00 Simple drunkenness
    - 10.01 Pathological drunkenness
    - 10.02 Complicated drunkenness
    - 10.03 Alcohol dependence
    - 10.04 Delirium tremens
    - 10.05 Alcoholic hallucinosis
    - 10.06 Alcoholic delusional disorder
    - 10.07 Alcoholic brain disease
    - 10.08 Other alcohol-induced mental disorders
  - 10.1 Mental disorders due to opiates
  - 10.2 Mental disorders due to cannabinoids
  - 10.3 Mental disorders due to sedatives and hypnotics
  - 10.4 Mental disorders due to cocaine
  - 10.5 Mental disorders due to other stimulants
  - 10.6 Mental disorders due to volatile solvents
  - 10.7 Mental disorders due to tobacco
  - 10.8 Mental disorders due to other psychoactive substances
  - 10.9 Mental disorders due to unspecified psychoactive substances
- 11 Mental disorders due to non-dependent substances (F19)
  - 11.0 Mental disorders due to non-dependent drugs
  - 11.1 Mental disorders due to organic chemical compounds

- 11.2 Mental disorders due to carbon monoxide
- 11.3 Mental disorders due to heavy metals and other chemical substances
- 11.4 Mental disorders due to foods
- 11.8 Mental disorders due to other non-dependent substances
- 11.9 Mental disorders due to unspecified non-dependent substances

A fourth digit code in 10.1–10.9 indicates:

- 1X.X0 intoxication
- 1X.X1 dependence syndrome
- 1X.X2 withdrawal syndrome
- 1X.X3 psychotic symptoms and affective disorder
- 1X.X4 amnesic syndrome
- 1X.X5 personality change
- 1X.X6 impairment of intelligence
- 1X.X7 neurotic symptoms
- 1X.X8 others

## 2 Schizophrenia and other psychotic disorders (F20, F22, F23, F24, F25, F29)

### 20 Schizophrenia

- 20.0 Paranoid schizophrenia
- 20.1 Hebephrenic schizophrenia
- 20.2 Catatonic schizophrenia
- 20.3 Simple schizophrenia
- 20.8 Other schizophrenia
- 20.9 Undifferentiated schizophrenia

A fourth digit code in schizophrenia indicates its clinical manifestation and course as follows:

- 20.X0 post-schizophrenic depression
- 20.X1 schizophrenia, in remission
- 20.X2 schizophrenia, residual state
- 20.X3 schizophrenia, deficit state
- 21 Schizophreniform psychosis
- 22 Paranoid psychosis
- 23 Transient psychotic disorders
  - 23.0 Bouffée délirante (Acute delusional episode)
  - 23.1 Induced psychosis
  - 23.8 Other transient psychotic disorders
  - 23.9 Transient psychotic disorders, unspecified
- 24 Schizo-affective psychosis
  - 24.0 Schizo-affective psychosis, manic type
  - 24.1 Schizo-affective psychosis, depressive type
  - 24.2 Schizo-affective psychosis, mixed type

- 25 Periodic psychosis
- 28 Other psychotic disorders
  - 28.0 Travelling psychosis
- 29 Unspecified psychotic disorders

### **3 Affective disorders (Mood disorders) (F30-F39)**

- 30 Mania
  - 30.0 Mania, single episode
  - 30.1 Recurrent mania
- 31 Bipolar affective disorders
  - 31.0 Bipolar affective disorder, manic phase
  - 31.1 Bipolar affective disorder, depressive phase
  - 31.2 Bipolar affective disorder, mixed phase
  - 31.3 Bipolar affective disorder, rapid cycling type
  - 31.8 Other bipolar affective disorders
  - 31.9 Bipolar affective disorders, unspecified
- 32 Depression
  - 32.0 Depression, single episode
  - 32.1 Recurrent depression
- 33 Cyclothymia
- 38 Other affective disorders
- 39 Affective disorders, unspecified

A fourth digit code in affective disorders indicates:

- 3X.X0 mild type
- 3X.X1 delirium or stupor
- 3X.X2 with psychotic symptoms
- 3X.X3 with somatic symptoms
- 3X.X4 chronic
- 3X.X5 in remission

### **4 Neurosis and psychogenic mental disorders (F34.1, F40)**

- 40 Neurosis
  - 40.0 Phobic neurosis
    - 40.00 Agoraphobia
    - 40.01 Social phobia
    - 40.02 Object phobia
    - 40.08 Other phobias
    - 40.09 Unspecified phobia
  - 40.1 Anxiety neurosis
    - 41.10 Panic disorder
    - 41.11 Generalized anxiety disorder



- 40.2 Obsessive-compulsive neurosis
- 40.3 Depressive neurosis
- 40.4 Hysteria
  - 40.40 Dissociative amnesia
  - 40.41 Dissociative fugue
  - 40.42 Dissociative identity disorder
  - 40.43 Hysterical psychosis
  - 40.44 Motor and sensory conversion disorder
  - 40.48 Other hysterical disorders
  - 40.49 Unspecified hysteria
- 40.5 Hypochondriacal neurosis
- 40.6 Neurasthenia
- 40.8 Other neuroses
- 40.9 Neurosis, unspecified
- 41 Psychogenic mental disorders (308; F43)
  - 41.0 Post-traumatic stress disorder
    - 41.00 Acute stress reaction (Acute psychogenic reaction)
    - 41.01 Delayed stress reaction (Delayed psychogenic reaction)
  - 41.1 Adjustment disorder
  - 41.2 Culture-related mental disorders
    - 41.20 *Koro*
    - 41.21 *Qigong* induced mental disorder
    - 41.22 Mental disorders related to superstition or witchcraft
    - 41.28 Other culture-related mental disorders
    - 41.29 Culture-related mental disorders, unspecified
  - 41.8 Other mental disorders related to psychogenic factors
    - 41.80 Reactive psychosis
    - 41.81 Neurotic reaction
  - 41.9 Mental disorders related to psychological factors, unspecified
- 5 **Physiological disorders related to psychological factors (F50-F59)**
  - 50 Eating disorders
    - 50.0 Anorexia nervosa
    - 50.1 Bulimia nervosa
    - 50.2 Nervous vomiting
    - 50.8 Other eating disorders
    - 50.9 Eating disorder, unspecified
  - 51 Disorders of sleep and wakefulness
    - 51.0 Insomnia
    - 51.1 Hypersomnia
    - 51.2 Sleepwalking

- 51.3 Night terrors
- 51.4 Nightmares
- 51.8 Other disorders of sleep and wakefulness
- 51.9 Disorders of sleep and wakefulness, unspecified
- 52 Disorders of sexual function
  - 52.0 Reduced sexual drive
  - 52.1 Erectile impotence
  - 52.2 Premature ejaculation
  - 52.3 Orgasmic dysfunction
  - 52.4 Vaginismus
  - 52.5 Dyspareunia
  - 52.8 Other disorders of sexual function
  - 52.9 Disorders of sexual function, unspecified
- 53 Disorders of autonomic nervous function
- 58 Other physiological disorders related to psychological factors
- 59 Physiological disorders related to psychological factors, unspecified
- 6 Personality disorders, impulse disorders, and sexual perversion (F60-F69)**
  - 60 Personality disorders
    - 60.0 Paranoid personality disorder
    - 60.1 Schizoid personality disorder
    - 60.2 Antisocial personality disorder
    - 60.3 Impulsive personality disorder
    - 60.4 Histrionic (hysterical) personality disorder
    - 60.5 Anakastic (obsessive-compulsive) personality disorder
    - 60.8 Other personality disorders
    - 60.9 Personality disorder, unspecified
  - 61 Impulse disorders
    - 61.0 Pathological fire-setting
    - 61.1 Pathological stealing
    - 61.2 Trichotillomania
    - 61.8 Other impulse disorders
    - 61.9 Impulse disorder, unspecified
  - 62 Sexual perversion
    - 62.0 Disorders of sexual orientation
      - 62.00 Homosexuality
      - 62.01 Fetishism
      - 62.08 Other disorders of sexual orientation
      - 62.09 Disorder of sexual orientation, unspecified
    - 62.1 Disorders of sexual preference
      - 62.10 Fetishistic transvestism

- 62.11 Exhibitionism
- 62.12 Voyeurism
- 62.13 Frotteurism
- 62.14 Sadomasochism
- 62.18 Other disorders of sexual preference
- 62.19 Disorder of sexual preference, unspecified
- 62.2 Disorders of sexual identity
  - 62.20 Transsexualism
  - 62.28 Other disorders of sexual identity
  - 62.29 Disorder of sexual identity, unspecified
- 68 Others
  - 68.0 Factitious disorder (Münchhausen syndrome)

## 7 **Mental retardation (F70-F79)**

- 70.0 Mild mental retardation
- 70.1 Moderate mental retardation
- 70.2 Severe mental retardation
- 70.3 Profound mental retardation
- 70.4 Borderline intelligence
- 70.8 Other mental retardation
- 70.9 Unspecified mental retardation

A fourth digit code in mental retardation indicates:

- 70.X0 Mental retardation with psychotic disorder
- 70.X1 Mental retardation with behavioural disorder
- 70.X2 Mental retardation with affective disorder
- 70.X8 Mental retardation with other mental disorders

## 8 **Mental disorders in childhood and adolescence (F80-98)**

- 80 Specific developmental disorders
  - 80.0 Developmental disorder of speech and language
  - 80.1 Developmental disorder of scholastic skills
  - 80.2 Developmental disorder of motor function
  - 80.3 Mixed developmental disorder
  - 80.8 Other specific developmental disorders
  - 80.9 Specific developmental disorder, unspecified
- 81 Pervasive developmental disorders
  - 81.0 Childhood autism
  - 81.1 Asperger's syndrome
  - 81.2 Heller's syndrome
  - 81.3 Rett's syndrome
  - 81.8 Other pervasive developmental disorders

- 81.9 Pervasive developmental disorder, unspecified
- 82 Hyperactive syndrome of childhood (Attention deficit disorder)
- 83 Conduct disorders
- 84 Emotional disorders of childhood
  - 84.0 Separation anxiety of childhood
  - 84.1 Phobic disorder of childhood
  - 84.2 Disorder of social sensitivity
  - 84.3 Elective mutism
  - 84.8 Other emotional disorders of childhood
  - 84.9 Emotional disorder of childhood, unspecified
- 85 Tic disorders
  - 85.0 Transient tic disorder
  - 85.1 Chronic motor or vocal tic disorder
  - 85.2 Tourette's syndrome
  - 85.8 Other tic disorders
  - 85.9 Tic disorder, unspecified
- 86 Behavioural disorders of childhood
  - 86.0 Disorders of excretion
    - 86.00 Enuresis
    - 86.01 Encopresis
  - 86.1 Feeding disorders of childhood
    - 86.10 Pica
    - 86.18 Other feeding disorders of childhood
    - 86.19 Feeding disorder of childhood, unspecified
  - 86.2 Stuttering
  - 86.8 Other behavioural disorders of childhood
  - 86.9 Behavioural disorder of childhood, unspecified
- 9 Other mental disorders, forensic conditions and conditions closely related to mental health (F99)**
  - 90 Unclassified psychotic disorders
  - 91 Unclassified non-psychotic mental disorders
  - 99 Forensic conditions and conditions closely related to psychological health
    - 99.0 Malingering
    - 99.1 No mental disorder
    - 99.2 Pathological somnolent state
    - 99.3 Suicide
    - 99.8 Other forensic conditions and conditions closely related to mental health

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