CULTURES AS A CAUSATIVE OF MENTAL DISORDER*

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INTRODUCTION

A REVIEW of the previous papers makes it evident that mental disorder is considered to be the product of multiple factors. The present paper is in harmony with this orientation, and its title, which was assigned to us, should not be interpreted as implying ideas of mono-causal relationship.

The discussion of our topic will be necessarily limited and selective, since talking about culture in its global sense touches on virtually all aspects of human behavior. Some areas such as family relationships and social change have been discussed earlier. Others such as cultural history and philosophy are too vast to be treated adequately in one chapter. We shall attempt, therefore, to present some points from salient literature, and to give impressions derived from several years of research dealing with socio-cultural factors and mental disorder.

DEFINITION OF CONCEPTS

Culture. As used here "culture" is a label for an abstraction that encompasses the total way of life of a group of human beings.

Many other definitions have been proposed, and several variants are current in the social sciences (25). Leslie White, for example, employs the word to mean a pattern of history which can be analyzed and understood without reference to the human beings in whom it is expressed (46). Culture in this sense is a determinant force which follows its own laws irrespective of individual psychology and acts upon, rather than interacts with, human personalities. Such a conceptualization provides a way of explaining other phenomena by means of culture as the causal element. We think, however, that despite some possible usefulness in White's "culturology" with regard to understanding the evolutionary path of society as a whole, it is too

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divorced from human variation to have relevance for the malformations and malfunctionings of personality known as mental disorders.

Other ways of defining culture point to the material artifacts produced by certain societies and to the relationship between patterns of livelihood and environmental resources. Our concept includes all these factors—history, adaptation to physical environment, technology—but its focal point is what Hallowell has termed the "psychological reality" of culture (15). By this emphasis, culture refers primarily to the shared patterns of belief, feeling, and adaptation which people carry in their minds as guides for conduct and the definition of reality. Besides concerning all aspects of human life—social relationships, economics, and religion, for example—culture as a totality contains patterns of interconnections and interdependencies.

Although all societies have a cultural heritage which is transmitted from one generation to the next, the particular style varies from one group to another. Where contrast is marked, it is possible to speak of different cultures. Thus cultures have been grouped as "Western and non-Western," "hunting and gathering," "agricultural," and "industrial" (17), or as "peasant societies" and "great traditions" (39).

In studying cultural factors which affect mental disorder, modern urbanites are, of course, as much the focus of attention as non-literate tribal groups. It is a common practice, however, to direct analysis toward situations which offer contrast to what prevails in our own culture with the hope of moving thereby into greater understanding of problems to which we are somewhat blinded by their being too close to us. It is for this reason that the examples to be cited here deal mainly with non-Western cultures, and the literature reviewed is primarily from the field of anthropology and the subfield "culture and personality" in which anthropologists and psychiatrists have collaborated.

Mental Disorder. Coming as it does at the end of the symposium, our definition of mental disorder should need little

elaboration. It is in keeping with the symposium's inclusion of all those behaviors, emotions, attitudes, and beliefs usually regarded as in the field of psychiatry. Such breadth of definition means that neuroses are encompassed as well as psychoses, sociopathic disorders as well as psychophysiological disturbances. It also means the inclusion of brain syndromes and mental retardation—conditions not primarily based on psychological experience but subject nonetheless to the influences of culture through practices of breeding, diet, care of the ill, use of drugs and intoxicants, and the training of the defective child.

How Cultural Factors May Be Thought to Affect Psychiatric Disorder

As a means of organizing pertinent ideas, what follows will be presented as a series of statements, each one supplying a different way of completing the sentence "Culture may be thought to. . . ."

1. *Culture May Be Thought to Determine the Pattern of Certain Specific Mental Disorders.* Names representing culture-specific disorders are well known in anthropological literature although they are not part of the standard nomenclatures of Western psychiatry. A list would include "amok" and "lâtah" both found in Malay (2, 43, 48), "imu" among the Ainu of Japan (47), "koro" in China (44), "witiko" among the Ojibwa Indians of the Northeast Woodlands (27), "piblokto" in the eastern Arctic (3), and "arctic hysteria" in Siberia (20). Each one embodies a constellation of symptoms found primarily in a given culture area, and often there is association between cultural beliefs or practices and the content of the symptoms.

"Witiko," for example, takes the form of a homicidal spree during which the individual may kill and eat members of his own family (7). In what could be called a delusional excitement the patient believes himself possessed by a spirit from his cultural mythology, the Witiko, a hoary cannibalistic monster

with a heart of ice. "Koro" is an anxiety state in which delusions concern withdrawal of the male sexual organs into the abdomen. It is associated with fear of death in a culture where it is believed that the sexual organs do disappear from corpses. Among the Eskimos, "piblokto" refers to a temporary derangement during which various bizarre acts are carried out such as dashing out naked into subzero weather or mimicking the sounds of Arctic birds and animals.

"Lâtah," "imu" and "arctic hysteria" are characterized by involuntary imitating, automatic obedience, shuddering, and fright. It is believed that women are more frequently sufferers from this disability than men. In some cultures certain people, especially old women, are known for this affliction, and it is considered sport to use gestures or words which will set off a reaction in which the victim goes into unseemly postures, dances to exhaustion, disrobes, and even harms herself or others.

There are accounts of whole groups of individuals becoming afflicted with a kind of mass hysteria, recalling the "dancing crazes" in Europe during the Middle Ages. One report tells of an instance in which a Cossack officer was drilling a group of Siberian natives. Each order he issued was shouted back first by one individual and then gradually by a chorus of all in the ranks. Every man appeared trapped in an exhausting and self-defeating repetition of the orders (and then curses) uttered by the increasingly infuriated officer (8).

A number of explanations have been invoked to account for such disorders. These comprise the ideas that they are:

1. Reactions based on physical disease such as malaria, tuberculosis, or luetic infection, but patterned in expression by cultural elements (43).
2. Reactions to the stress of severe environment, starvation, or long periods of isolation (37).
3. Reactions to the stress and strain of role characteristics in the culture (1).
4. "Hysteria" (6), that is, variations of a syndrome familiar in Western clinics and which is referred to in the American

Psychiatric Association nomenclature as "dissociative reaction" (4).

These explanations are not mutually exclusive. Some of the culturally localized syndromes can be considered as neurotic states involving suggestibility, and in which the content of symptoms is produced by the experience of growing up in a particular culture and being inculcated with its shared sentiments. Contributing factors may then be the stress of environment or roles. Dynamic mechanisms or noxious agents can also be regarded as components in the origin and course of the disorder.

The idea that these disorders are hysterical should, however, be treated with some caution. This is said partly from our feeling that such a conclusion is deceptively complete and hence may cut off effort toward penetrating to a less superficial level of understanding. There is also the possibility that it expresses a bias of the Western clinician who may have some tendency to consider any seemingly bizarre behavior as hysterical if there is no organic basis and if it cannot be called schizophrenia. This is further encouraged if the person exhibiting such behavior is uneducated from the Western point of view, is "simple" and "child-like"—qualities which are part of the stereotype we hold of "primitives." It would seem wise not to blanket aberrant behaviors found among the people of this or that culture with the term and concepts of "hysteria" (or of schizophrenia for that matter), but rather examine to see if some cases, at least, may not be on a somewhat different basis from what we are accustomed to see in the West. And even when "hysteria" turns out to be a valid label such an approach might, through comparisons and contrasts, increase our knowledge regarding the nature of the condition, not only as it occurs among non-Western peoples, but also among ourselves.

2. *Culture May Be Thought to Produce Basic Personality Types, Some of Which Are Especially Vulnerable to Mental Disorder.* The concepts of "basic personality type" (21, 22,

33), "modal personality" (16, 19), and "national character" (35, 14) were developed by anthropologists and psychiatrists to account for the fact that certain personality traits and certain inclinations to symptoms of psychiatric significance seemed to be associated with growing up in particular cultures. Being middle class American, Japanese, Russian—or, as described in Ruth Benedict's classic volume, being Zuñi, Kwakiutl, or Dobu (5)—appears to predispose individuals toward particular kinds of symptoms. In the employment of these concepts, culture and personality were held to be essentially two aspects of a single phenomenon (42). This opened the way for studying personality through cultural data rather than through the behavior of individuals. The early work in this field by Kardiner and Linton had its foundation in exploring ethnographies and the folklore of non-literate tribes. Through analysis of child-rearing practices, kinship arrangements, socio-structural stresses, and especially religion and myths considered as projections of common, underlying personality attributes, "basic personality types" were postulated for different cultures.

Basic personality was thought of as a central core of values and attitudes which culture stamps into each of its members—a common denominator underlying each person's individual elaboration of life experience. Once a type had been described, it could be assessed from the psychiatric point of view as to its vulnerabilities. Thus, if at the cultural level—that is, group practices and beliefs—patterns were found that had psychiatric implications it was assumed that individuals in that culture would have these as psychological weaknesses. Whole cultures were described with psychiatric terms heretofore reserved for diagnosing individuals. If a society exhibited patterns of suspiciousness, hostility, witchcraft fears, and ideas of grandeur as in the potlatching Indian groups of the Northwest coast, there was a tendency to call such cultures "paranoid."

Since a major component of almost every clinical definition of psychiatric disorder is some deviation from the expected behavior and shared sentiments of the group to which the indi-

vidual belongs, the use of clinical terms for conforming, group-oriented behavior involves a contradiction. At best, it is the employment of unclear descriptive labels to characterize patterns of behavior manifested by a society. At worst, the clinical implications of the words are transferred to the group behavior, and dynamic interpretations are made in this framework. Since the behavior of people in accord with and at variance with group patterns implies major differences of psychological process, these usages can be exceedingly misleading. To say that a group is "paranoid," for instance, may be passable though not admirable if by this is meant behavior that is suspicious and hostile. If however, the word is intended as some kind of explanation based on individual psychology, then many pre-judgments and unsound inferences from individual to group behavior may enter the picture. One runs the risk of anthropomorphizing the group and regarding it as a deviant individual among a number of other anthropomorphized groups. It is one thing to say that functioning at the personality level and functioning at the socio-cultural level display similarities, and that how well they fit together is significant for adequate functioning at each level. It is another thing, however, to go beyond this and use identical terms in referring to these different levels of abstraction. This is especially true when the psychiatric terms invoked to identify and classify cultural patterns are not well standardized even at their source—psychiatry.

Theories concerning basic personality may also be criticized for a tendency to consider cultural factors as over-riding variations based on genetic influences affecting temperament (13) and for ignoring the possible effects of endemic disease and other physiological factors. For the most part "basic personality types" have been derived solely from cultural behavior or from the results of projective tests like the Rorschach. Thus far vulnerability to, or resistance against, mental illness has been postulated without concomitant investigation of the actual distribution and patterning of psychiatric disorder in the population.

Our own inclination is toward a less specific functional view of socio-cultural groups and the personalities which compose them. By this is meant the aim of understanding how psychiatric disorder can arise, take shape, and endure, as a result of interaction between individual functioning (personality) and group functioning. Since a discussion of this viewpoint has been previously published by one of us (30), we shall not here elaborate it further.

3. *Culture May Be Thought to Produce Psychiatric Disorders through Certain Child-Rearing Practices.* This point is closely allied to its predecessor. The difference is that while basic personality types have been formulated from looking at cultures as wholes, the focus here is directly and more exclusively levelled at socialization practices and the early years of life experience. Freudian theory has provided a means of organizing data from different cultures with regard to toilet training, nurturing, control of aggression, weaning, and encouraging independence (11). It has also provided a way of interpreting cultural variations with regard to probable significance for mental disorder among adults. Cultures portray remarkable variation in customs such as swaddling, use of a cradle-board, bottle or breast feeding, varying modes of punishment and reward, and permissive or restraining parental attitudes. This has given impetus to many hypotheses regarding the differential occurrence of psychiatric disorders.

The risk of this approach is to give undue emphasis to one set of factors, and to one period on the life-arc of individuals, to the exclusion of all other factors and periods of personality growth and development. Few would quarrel with the importance of the early years of life, but to assume that the experiences of infancy determine everything that comes afterward so far as origin, course, and outcome of psychiatric disorder is concerned, is to assume more than the knowledge currently at our disposal warrants. Different sets of dynamics are relevant to individual functioning at different stages of life. Physiologi-

cal and psychological changes in maturation and involution are probably of considerable significance in some kinds of mental disorders. Since our interest is in discovering cultural factors relevant to the whole range of psychiatric illnesses, it is important to recognize that adolescence, maturity, and senescence are viewed and defined as variously in different cultures as is child-rearing.

4. *Culture May Be Thought to Affect Psychiatric Disorders through Types of Sanction.* It has long been accepted that there is a relationship between some kinds of disorder and the manner in which a patient handles the problem of conformity or nonconformity—the sense of being right or wrong in the eyes of his social audience. There is considerable variation among cultures regarding how punishment is meted out to those who defy accepted beliefs and standards about what ought and ought not to be done. Cultures also vary in what is defined as transgression and the kinds of responsibility demanded of members. Some groups operate on the principle that society at large is the controller of moral conduct; others appear to maintain social control by implanting in individuals the job of self-monitoring conduct. These two types—"other-directed" and "inner-directed" in Reisman's terminology (40)—have usually been called "shame" and "guilt" cultures in anthropological literature. A critical discussion of this orientation is given by Piers and Singer (38). It has been thought that distinctive forms of psychopathology may be found in "shame" cultures where the atonement for sin calls for some kind of public demonstration such as a confession, while other kinds of symptomatology may be fostered in "guilt" cultures where expiation is left to the lonely world of conscience. One can theorize that where the group as a whole is the court to which account must be made, there would be a tendency for psychiatric disorder to take the form of antisocial behavior, aggression of the sociopathic type. Where individual super-ego is stressed, there might be an inclination to self-directed punishment and depression. In

short, and in overly simple terms, one type of culture can be thought to encourage symptons which are disturbing to the group, while the other encourages symptoms which are disturbing to the individual who has them.

With regard to the kinds of behavior for which people are punished, it has been noted that some cultures institute negative sanctions only against what is defined as controllable, while others include involuntary behavior as well (23). Among some peoples, menstruation, multiple births or impotence are thought to be defiling to the whole group or at least an affront to cultural expectations. In a personal communication Dr. T. A. Baasher of Khartoum North has told one of us* of the Ingassuma tribe in the Sudan where it is believed that the mother of twins has the evil eye. He reported an instance in which such a mother committed suicide by running her head against a rock while the members of her village looked on.

The psychological burden related to the occurrence of certain uncontrollable and not uncommon events, and to some kinds of physiological processes, e.g. menstruation, may be of a magnitude that makes it appropriate to say that a given culture has a serious potential for psychiatric disorder. At least it seems clear that sanctions of this nature have a quite different meaning with regard to mental health from those which relate the occurrence of insanity to more or less self-willed acts such as breaking incest taboos among the Navaho (41), or masturbation as found in some of the folk beliefs of our own culture.

5. *Culture May Be Thought to Perpetuate Psychiatric Malfunctioning by Rewarding It in Certain Prestigeful Roles.* Under the last point attention was focussed only on negative sanctions. We turn now to the positive side—reward—and also more explicitly to the concept of role (32). The relationship between socio-cultural role and mental disorder is complex, and we shall deal with it in two parts: here in terms of roles

* AHL

which may attract individuals who have certain disorder tendencies and in Statement 6, below, in terms of roles which may produce some types of psychiatric disorder through being seats of conflict and stress.

In non-Western cultures the roles of medicine-man and holy-man—shaman or sahu—are examples of social positions for which, it has been thought, personnel are recruited from unstable members of the culture—hysterics and psychotics (24, 9). Taking the shaman as an instance, behaviors connected with the role have been described as indicative of disorder because emotional lability and frenzy characterize the seance, because the shaman has charismatic dominance over the group of individuals for whom the curing ceremony is held, because the shaman believes that he loses his own identity and becomes possessed by an over-world spirit, and because a fit or epileptic-like seizure culminates the performance.

There are, however, some considerations to be taken into account in following this line of thought. Just because the shaman's behavior resembles psychiatric symptoms is not a warrant for assuming that they are in fact psychiatric symptoms. Whatever else it may be, his behavior is part of the role of shaman and hence it may or may not have a relationship to his personality as a whole which would qualify him as mentally ill in Western terms. The settling of this question would require a thorough psychiatric examination of the person. To make a clinical diagnosis on the basis of role behavior alone is scarcely on a firmer basis than making a diagnosis from cultural patterns as noted on page 46.

What in shamanistic behavior may appear hysterical or psychotic to the Western psychiatrist is, to the people concerned, a time-honored ritual through which practitioners heal sick people or divine the future. Hence the "symptoms" of the shaman may in fact be the result of learning and practice. His role embodies a traditional plan for serving particular ends, and it is available in the culture as a model. The patterning of

behavior after this model can, of course, vary greatly in its success, from excellent to poor.

It can also be assumed that a variety of personality types will be attracted to the model and role for a variety of reasons, some making a conscious selection while others act in response to both unconscious factors and extraneous circumstances. In the cultures where shamans are found, there is usually much less diversification of roles than is the case in Europe and America. There the business of life may be managed through nearly all the men being hunters, farmers or warriors, with the women in the main being home-makers. The role of shaman, consequently, may be almost the only variant possible and it is thus likely to collect incumbents for a wide variety of reasons, some of a psychiatric nature, some for matters of temperament, some related to superior and creative qualities, and some based on physical abnormality—blindness or loss of a limb—which makes achievement of the more prevailing roles impossible. It seems to us, that while some shamans or medicine-men may be suffering from psychiatric disorder, this is probably not by any means the case with all.

The concept of role is traceable in part to 'role' as it is known in the theater. This may serve as a reminder that any given role as performed by an actor is not necessarily a direct and simple reflection of his own personality. Very few Ophelias have really been mad, and mad actresses do not necessarily perform Ophelia well. At the same time we do not wish to suggest that, because they may learn their part, most shamans are conscious fakers. On the contrary, it would seem likely that the ability to perform is enhanced by belief in the importance of the part.

In our own culture there are doubtless certain roles which resemble that of shaman in that they not only offer opportunity to mentally healthy personalities but also provide shelter for those with a certain amount of deviance. The artist comes to mind in this connection. Of course, many artists are mentally healthy, but it is possible for the arts to provide an opportunity

for an ill person to express himself creatively and thus have a position in the social system. Artists are often accorded leeway—indeed, may acquire prestige—in the expression of psychiatric symptoms which, if evinced by people in other social roles, might be reason for sanctions, or even hospitalization. Places such as the Left Bank, Greenwich Village, and North Beach give a social medium where fairly large numbers of sick people can float. These areas contain not only the genuine artist but shelter many who act like poets and painters without ever becoming highly original or productive. Certain religious groups and colonies have similar sheltering characteristics for malfunctioning personalities.

6. *Culture May Be Thought to Produce Psychiatric Disorders through Certain Stressful Roles.* With this statement attention shifts to the effects of roles rather than their patterning and appearance. It is possible to conduct analysis so as to identify roles considered to be psychologically damaging, even to the extent of producing psychiatric disorder. For the most part this approach has been typical of sociology, in contrast to anthropology's focus on child-rearing.

Roles can be considered stressful in a number of ways. One is the problem of ambiguous definition regarding expected behavior. This is especially true of new roles developed in situations of socio-cultural change where tradition gives no guidelines for assisting the recently emancipated to adapt and fulfill his new state. The principle is pertinent whether we observe a freed slave, a modern career woman, or a person in the limbo between magical and rational thought.

Roles may also present the person with inherently conflicting standards of behavior; the man who dedicates his life to humanitarian goals may come to feel he can reach a position effective for launching such a program only by being ruthless and competitive. Or a person may have to fill at one time several roles which make contradictory demands on his personality. We see this for example in students who have cast

themselves in the role of liberals yet attempt to be loyal offspring to conservative parents.

The relationship between role stresses and a particular kind of psychiatric disorder has been reported by Linton as occurring among the Tanala of Madagascar (34). These people have a condition called "tromba" which occurs mainly among second sons and childless wives. This is to be understood in the context of a culture in which inheritance and privilege are based on primogeniture and in which marriages are polygamous with the value of women related chiefly to child-bearing. Not only are role stresses and lack of social value involved, but also the mental illness itself gives opportunity for compensating prestige ("secondary gain"). Normally the family gives little attention to people filling such subservient roles as younger sons and wives without children, but for this illness the family group will finance an elaborate curing rite with attention focussed on the tromba-sufferer.

Innumerable other examples could be given of role stresses peculiar to this or that culture, and it seems probable that many of them are associated with some kind of psychiatric disturbance. It is a hard matter to pin down, however, for while individually persuasive cases can be found, research encounters problems of definition and the assembling of statistics adequate for conclusive statements.

7. *Culture May Be Thought to Produce Psychiatric Disturbance through Processes of Change.* It was intimated in the last section that some of the most striking examples of stressful roles pertain to cultural change—that is to say a given role is conflict-laden because of changes in the web of socio-cultural situations with which it is related. Being a wife and mother may take on this character if, in the changing cultural situation, a woman is also expected to hold a job, vote, be educated, and so forth.

Literature on the relationship between mental disorder and social change through immigration, mobility connected with

war, acculturation, and detribalization was reviewed in the last paper. It is not, therefore, appropriate to develop it further here except to indicate that culture is not static social organization and that in the world today, any study of culture is of necessity a study of change—changes of various sorts, at various rates, and with varying degrees of integration and conflict. Although there are numerous methodological problems connected with the use of hospital admission rates or projective tests, we feel that with advances in methods of case finding it is in the area of cultural change that some of the most revealing findings will occur that bear on the relationship between culture and mental disorder (31).

8. *Culture May Be Thought to Affect Psychiatric Disorder through the Indoctrination of Its Members with Particular Kinds of Sentiments.* There is now considerable literature in the social sciences on the differences between cultural groups in regard to socially shared feelings and ideas about man, nature, and reality (18). For the most part this has been concerned with values or beliefs held by relatively normal individuals. Implications regarding psychiatric disorders have, however, been pointed up in a number of ways. It seems probable that some cultures equip people with patterns of fear, jealousy, or unrealistic aspiration, which may foster mental illness; other cultures may be based on themes of self-acceptance and a relationship to natural forces which are more conducive to mental health.

Reality-testing in the tradition of Western empiricism is, for instance, a criterion advanced by modern psychiatry as an essential component of sanity and mental health. With such a base for discrimination, it has been suggested by Kroeber that the practice of magic and witchcraft and the adherence to non-objective beliefs characteristic of "primitive" peoples indicates a diffuse and subtle paranoia (24). Few would argue against the value of reality-orientation as a mark of psychiatric health, but, as many have pointed out, the standard cannot be

determined exclusively by scientific rationalism. A better criterion is whether or not a person is capable of assessing and acting in response to reality as it is defined by the group in which he grows up. This opens the way for understanding the relationship of religious faith, folk belief, and emotional coloring of attitudes to the development and maintenance of healthy adjustments and maladjustments. From such a perspective have come attempts to employ concepts which emphasize equally the cognitive, affective, and basic-urge (largely instinctual) forces which come into play in human functioning, and in that light to analyze the significance of differences in the cultural patterning of belief. The Eaton and Weil study of mental illness among the religious communities of Hutterites takes this aspect as one of its points for analysis (10). And it is central in the Stirling County Study (30).

9. *Culture per se May Be Thought to Produce Psychiatric Disorder.* All human beings are born and develop in cultural contexts which impose regulation of basic human urges. It has been thought that this is both universal and psychologically noxious with repercussions evident throughout the human race. We may all be, in short, like Chinese women with bound feet. Variations, however, are to be found in the degree of impulse-repression. Thus according to this view, simple and "primitive" societies with cultures which permit expression of sex and aggression are, on the whole, a healthier environment than complex, modern civilizations which compress infants into highly artificial patterns of existence. This is the kind of thing Freud had in mind when he spoke of 'civilization and its discontents.' (12)

Most social scientists today would not accept such inherent assumptions about the character of "primitive" and "civilized" cultures. The distinction has limited usefulness and then only when the terms are carefully defined. The more we have learned about "primitive" cultures, the more impressed we are with their potential for being both repressive and suppressive.

There is much in favor of the general idea that some kinds and degree of psychiatric disorder may be the price paid for being socialized, somewhat as backache and curvature of the spine may be part of the price paid for walking on our hind legs.

10. *Culture May Be Thought to Affect the Distribution of Psychiatric Disorders through Patterns of Breeding.* This statement and its successor—the final point we shall present as a way in which culture may be thought to relate to mental illness—stand on a different basis from all the previous items. Until now each statement has shared with others the characteristic of assuming that psychological transactions are the main, if not the only intermediary between cultural factors and the emergence and shaping of psychiatric disorder. This has, in fact, been the principal orientation of those concerned with culture and its bearing on mental disorder.

Culturally-prescribed inbreeding is found in many groups of people, particularly with reference to some non-Western cultures, elite families, and small communities which for one reason or another live in isolation. If such groups begin with a prevalence of hereditary factors which make for mental retardation, schizophrenia, manic-depressive psychosis or other forms of emotional instability, it is to be expected that these conditions will become accentuated and prevalent in the group. Laubscher's early work in the field of cross-cultural psychiatry illustrates an attempt to relate the amount of schizophrenia among the Bantu of Africa to the pattern of cross-cousin marriage (29).

The same kinds of factors may be at work at more subtle levels, and in larger groups. Thus the accumulating evidence in the West that there is greater prevalence of psychiatric disorder in the lower socio-economic ranges, has one explanation in terms of a socio-cultural process which produces a downward drift and interbreeding of people with genetically determined disabilities.

Heredity as a factor in psychiatric disorder suffers both from

over-emphasis and neglect. Heredity as such is considered *the* matter of importance in many centers of psychiatry, particularly in Europe. But the question of cultural patterns and their shaping of hereditary processes is scarcely considered, at least in any systematic way. In other psychiatric centers—especially in the United States—and among most social scientists, the whole of heredity is by-passed in favor of psychological factors. Here culture is apt to be given more emphasis but not in connection with the distribution of genes.

11. *Culture May Be Thought to Affect the Distribution of Psychiatric Disorder through Patterns which Result in Poor Physical Hygiene.* Our concern here is the role of physiological factors as the intermediary between culture and psychiatric disorder. Culture and cultural variation can be supposed to influence the distribution of noxious agents and traumata, and also the distribution of compensating factors and capabilities for resistance. In many non-Western cultures, for instance, contacts with the West which have demanded acculturation and abrupt industrialization have been accompanied by the spread of syphilis, tuberculosis, and many other diseases. Directly and indirectly these can foster disorder, although some have more potential in this regard than others. Of equal importance to the introduction of disease through contact, is the lack of native preventive and therapeutic measures.

Diet, based not only on availability of resources but also cultural preferences, may result in vitamin deficiency and malnutrition which in turn can affect the nervous system. There may also be cultural practices about child delivery, or the use of herbs and concoctions which make for brain damage. In some areas drugs have widespread use in native therapy, in recreation, and in religious ceremonies. There may thus be long-term degenerative effects as well as more immediate toxicities.

Concluding Notes

Given the impressions sketched above, what conclusions can

be drawn with regard to epidemiological studies of psychiatric disorder in different cultures as a means of expanding knowledge of etiology?

One can say to begin with that if the emphasis is on a primary target of inquiry such as genes, damage to the brain, or family relationships, the cultural context will be of some importance even if secondary. It will be one of the sets of factors to be considered in understanding how the damage comes about -whether *via* hereditary, physiological or psychological means- how it is spread and perpetuated and how it may be controlled.

If we take culture-in-relation-to-psychiatric-disorder as the primary matter for attention, then a major gap is apparent: an incomplete descriptive account of the varieties of psychiatric disorder to which human beings are susceptible across the world. The magnitude of this gap becomes apparent as soon as one begins to look into it. We do not even have a reasonably complete account of psychiatric disorders as these occur in a selection of contrasting cultures. Many of the localized types of illness such as those mentioned on page 448 are actually based on very few observations, some of them carried out years ago by non-psychiatrists. Despite the fact that psychiatric clinics exist in many non-Western societies, problems of nomenclature, variable criteria, and a Procrustean emphasis on Western systems of classification make assessment and comparison very difficult. Beyond this is a void consisting in the unknown numbers of persons who, though disturbed, do not ever come to clinical attention.

The importance of supplying this lack in our knowledge bears first of all on the descriptive aspect of scientific procedure. While we recognize that not everyone would accept systematic description as a basic component of the scientific process, it would be a digression to argue the case in general terms here. Suffice it to say, then, that if one does believe as a principle that this has its place and contribution to make in the study of man (no less so than in the study of other creatures, or of

the earth's crust, or of the stars) then the gap is in obvious need of filling. Although it will take years of painstaking work by many observers, it is a necessary foundation on which to base other kinds of study.

Stepping down, however, from the level of general scientific desirability with its implied faith in serendipity, it is possible to point out a number of more specific goals and opportunities. For one thing, description paves the way for assessment of frequency—be this in terms of prevalence or incidence. Such counts will be essential ultimately, both in critical problems of basic research into etiology and in providing information for programs concerned with treatment and prevention.

Description and the use of these descriptions as criteria for counts of frequency (epidemiology), bring with them the need for developing a system of classification that will stand up across cultures. While this may look on the surface like a rather dry and laborious exercise in taxonomy, shafts run out from it into the foundations of psychiatry, and there may be consequences that will profoundly alter many accepted ideas and change significantly the way the field is perceived.

Psychiatry itself, like most of the rest of medicine, is a product of Western culture. As such, it embodies ideas of illness and wellness, of normal and abnormal, of well-functioning and malfunctioning, of adaption and maladaptation which have their roots in our own shared sentiments regarding the character of reality, of what is desirable, and of what ought to be desired. While the range in these matters is considerable in the West itself, cultural studies make it clear that it is not so great as when the whole world is considered. In other words malfunction, one of the major components of a definition of psychiatric disorder, shifts its character from culture to culture.

This problem is not necessarily limited to differences of shared preference and shared belief as supplied by one culture in comparison to another. It may involve not only feeling and knowing but also the process of thinking. The studies of Mertens and his co-workers using psychological tests in the Bel-

gian Congo suggest that natives who have had a European kind of education think like Europeans, while those who do not, retain a framework quite different from the Aristotelian logic which is second nature to most Westerners (36, 28, 45).

The indications of such plasticity and difference should not lead one to hold that the range of psychological variation is limitless and that there are no transcultural consistencies. Even today there is good reason for believing that universals exist. While definition of malfunction and threshold of tolerance may vary from culture to culture, it is almost certain that mental retardation is known in all, as are also symptoms very like schizophrenia and depression. One of the opportunities in cross-cultural studies is to discover and more precisely specify universals and differentiate them from more localized disorders. Such a step would be a major advance in narrowing the field of possible etiological factors requiring investigation and would point to some as being more important than others.

A system of classification, together with its definitions and underlying concepts, which would stand up across cultures and take into account the variable and less variable factors, would probably result in some rearrangement and reorientation for psychiatry. At the least it would call for assessment of etiological theories against a broader background and it should bring to the fore the notion that the etiology of diagnosis in this or that cultural setting is a matter that has to be understood before there can be understanding of the etiology of disorder.

Psychiatric disorders are not, however, the only relevant area in need of taxonomic consideration. A problem of equal importance is the development of a system of classification for ordering the socio–cultural environment in a manner relevant to our interests in the effect of socio-cultural factors on the origin and pattern of psychiatric disorders. While some consideration has already been given to cross-cultural and transcultural classification of psychiatric illness, very little has been given to categorizing cultures and social groups from this point

of view. Yet without this there is severe limitation in generalization, in cross-comparison, and in the identification of salient socio-cultural factors.

While it is our opinion that the problems just mentioned are of first-order importance, it is not our intention to assert that they are the only questions worth tackling. Our inclination is rather to feel that the broad context needs to be kept in mind in any specific study and the limitations recognized which will prevail pending development of systematic knowledge in the wider areas. With this reservation, there is much to be said for pushing ahead with particular studies such as those concerned with relating culture, personality, and psychiatric disorder.

It may well be that the descriptive studies of psychiatric disorders in non-Western cultures could be combined and articulated with investigations of culture and personality. For instance a common syndrome in the Western Region of Nigeria is excitement (26). It apparently shows up in the clinics there with far greater frequency than it does in Europe or North America. It is also a component of disorders which have other features as well. One has the impression, moreover, that excitement at a somewhat lower level, though still high by Western standards, is a prominent aspect of many personalities. It also seems that the culture itself sets a positive value on states of frenzy under certain conditions. What are the relationships of these behaviors to each other? Are there also hereditary and physiological factors to be considered? Is there, for instance, any connection with what appears to be an unusual frequency of malignant hypertension? What is the part played by cultural change?

The promise in pursuing such questions is not at present in terms of revealing highly specific relationships such as was done by Pasteur in his work with micro-organisms, but rather in assembling evidence as a means of feeling out the more and less probable hypotheses for later, more crucial investigation. It is largely a matter of finding suitable targets and discovering

the right questions to ask of nature—questions which are answerable by the further procedures of science.

What has been observed above with regard to studies of culture, personality and psychiatric disorder, apply also to investigations of roles, child-socialization, and other questions of a similar type.

With all cultural studies, the possible contribution of hereditary and physiological factors should be given consideration. Their recognition is important, just as is the case with culture when the primary emphasis is on one of these other topics.

In concluding our paper, we should like to return again to a point mentioned earlier. This is our impression that comparative study of change is one of the most fruitful opportunities for uncovering the nature of socio-cultural factors in relation to psychiatric disorder. We regard descriptions and analyses of cultures at a given time as prerequisite to this, as fixing-points in terms of which to understand shifts. If, following a suggestion made earlier, we were to attempt to build a system for classifying cultures in such a manner as to have maximal relevance for mental health and mental illness, we would choose types of socio-cultural change as our starting point.

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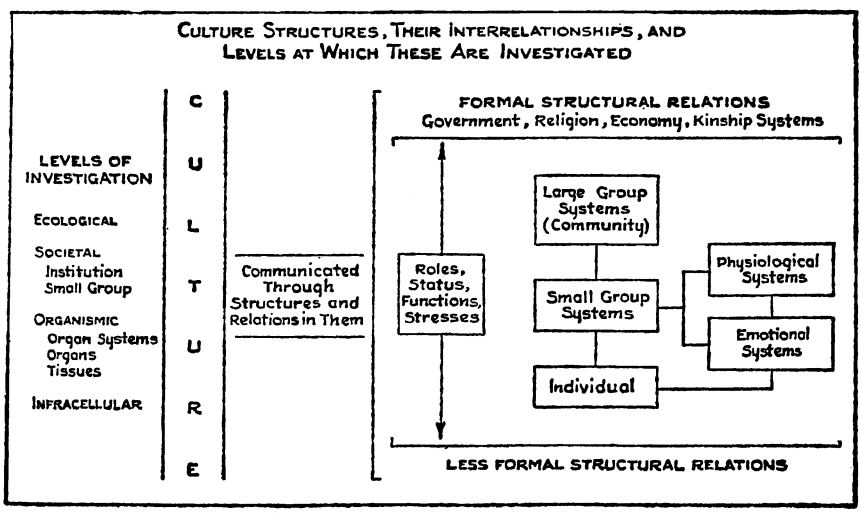
Discussion

Dr. George Rosen: One of the things that has bothered me as we went along yesterday and today has been the fact that we have been discussing a very large, global subject without specifying the level at which, or the realm of discourse within which, the discussion has been taking place.

In certain areas this has been more explicit than in others. For instance, Dr. Böök made explicit what he was talking about when he started out, but some of the other discussions have not had this advantage. It might be useful if we were to look at the levels of investigation, at least as I envisage them, and I have made the following diagram or list which ranges all the way from the ecological (conceived very broadly here as relationship of organism to environment), through the societal (which is one aspect of the ecological) and the various structural elements of the society (institutions, the small group), and then the organismic level (the organ systems) and finally the infracellular aspects.

Dr. Leighton has given a definition of culture which is in some way related to any one of these levels. I think as I go along you will see that while I could follow this, I am going to stick to certain things simply because Dr. Leighton has made my task in one sense easier and in one sense more difficult. He and his coauthor have set forth a series of specific propositions. I can take issue with these propositions if I wish, and I will to a certain extent, or I can disregard



them, which I have done at certain points. I have a number of degrees of freedom in this respect.

Also in relation to culture, there is another element that I think one ought to keep in mind as we discuss this paper. Culture is one abstracted aspect of a global entity, namely, a society, and a society conceived as a system. In this connection, one has to keep in mind that when I talk about culture there is always implied the concept of structure, and that there are various avenues and channels through which culture is both produced and disseminated. In other words, one can think of religion, religious institutions, as producing what we call culture and at the same time being affected by what we call culture.

What are we dealing with? An analysis of culture as causative of mental disorders may usefully begin, as Dr. Leighton has done, by defining culture. It is a concept which sums up the patterned ways of acting, feeling, and thinking of a group of people; the ways in which they arrange and interpret group life, both cognitively and affectively; the symbols used for this purpose; and the levels of awareness on which these processes occur permeate individual and group behavior. In varying degree the members of the group are shaped by the culture psychologically and physiologically. Culture is not a matter of a single generation, but is shaped by the past history of the group. Here I would take issue with Toynbee's position that there are groups without history and groups with history. This is peculiarly Toynbeean.

I think in a larger sense one has to look at the social organization of the group to see that it is not only permeated by culture but produces culture. For example, one of the more interesting religious groups of the present is the sect known as Jehovah's Witnesses. This sect represents the 20th century version of a cultural tradition that can be traced back to the Judaeo-Christian culture around the beginning of the Christian era, namely, the idea of the Last Days, the coming of the millenium and the end of history; in short, the sect derives from an ancient eschatology.

Culture is in one way independent of individuals and affects them even when they are not aware of such action. It is in terms of a given culture that an individual learns to perceive his social environment, and here I think we can link our discussion with some of the things Dr. Murphy talked about. Consequently, culture as an his-

torical product and as an element in social processes must be seen along the axis of both past and present time. In other words, how a culture developed, what it meant in the past, and what it means in the social dynamics of the present, are all revelant to our topic.

Our topic may be viewed from this standpoint. Most of the data presented at this conference have been from the present or the recent past. I believe it may be useful, therefore, in treating or discussing the subject of culture as causative of mental disorder, to offer some data from the distant past as well as from the present.

I start out by taking Dr. Leighton's first point that culture may produce specific mental disorders, and I have chosen as an instance the famous religious revival in Kentucky in 1800 known as The Great Revival. For those who are interested in this, there are a number of sources. I might mention the relevant section in Frederick Davenport's PRIMITIVE TRAITS IN RELIGIOUS REVIVALS (2), a short account but a useful one. For a number of days thousands of people gathered to listen to preachers who exhorted them to repent, to cast off the devil, to be washed in the blood of the Lamb and to be reborn. Verbal pictures of fire and brimstone were created in sessions which went on for hours, often at night in the light of large bonfires. Soon a number of individuals began to fall down in a state of unconsciousness. Others rolled on the ground. Still others began to exhibit jerky, quivering movements, and yet others ran around on all fours barking like dogs.

This instance was not the first of its kind and not the last. Religious revivals have been a feature of the American scene and have appeared in other parts of the world. It is, however, instructive because it involves a number of factors which help us, I believe, to understand how a culture may produce such behavior as I have described. Most of the instances that I shall cite following this are cases of dissociative reaction or what has been termed hysteria.

First of all, it is essential to know the cultural context. This is the first methodological point I would like to stress: that in many of the reports that we have, there has been no real study of the cultural context.

The culture must be understood before one can undertake to interpret behavior as normal or pathological. For example, in the Kentucky revival that I mentioned briefly, the group had certain behavioral expectancies. Methodism had somewhat earlier produced

similar phenomena, and so had the earlier New England revival of the 18th century. Secondly, the concepts of Hell, the Devil, and other ideas were part of the culture and generally accepted. Thirdly, the circumstances: a large crowd, the darkness, and the shifting lights of bonfires created an atmosphere favorable to release of conscious controls and relief of tension. Finally, the need to release tension due to hardships and perils on the frontier is another factor that I believe cannot be overlooked.

Are there other comparable situations in which one can find similar factors? And do these factors operate in the same way? The Kentucky revival is a case from which one can derive certain factors for further study. Are there situations in which a culture intentionally elicits dissociative reactions?

Where the mystical experience is a desirable value, ways are developed to elicit such behavior. Heinrich Zimmer, in his discussion of Vedanta (13), says that the adept reaches a point in his spiritual development at which he becomes identified with the Personal Creator of the World Illusion:

> He feels that he is at one with the Supreme Lord, partaking of His virtues of omniscience and omnipotence. This, however, is a dangerous phase for if he is to go on to Brahman, the goal, he must realize that his inflation is only a subtle form of self-delusion. The candidate must conquer it, press beyond it, so that the anonymity of sheer being, consciousness and bliss may break upon him as the transpersonal essence of his actual Self.

I will leave it to you to judge how similar this may be to certain psychopathological conditions. Analogous instructions can be found, for example, in the exercises of Ignatius of Loyola and in various other writings concerned with mysticism. Similarly, the Shakers had a method of rolling the head back and forth to elicit the ecstatic state which they desired. At some times they sang, and at others, danced. Here are very intensive definite patterns of behavior to elicit what, in the catalog of the American Psychiatric Association, is termed psychopathological phenomena or states.

Here I shall say a few words about the dancing mania to which reference has been made in a number of papers. This has been referred to in passing several times and illustrates the first point I made. Much of what is said about these phenomena has been taken

from the English translation of Hecker's THE EPIDEMICS OF THE MIDDLE AGES (5).

The German word for dancing mania is *Die Tanzwuth* which, correctly translated, should be the dance frenzy, *Wuth* meaning anger or, as in *rasende Wuth,* frenzy. There has been a semantic confusion here which tends to prejudge the issue of the occurrence of psychopathological phenomena. Secondly, closer examination of the context reveals that it occurred in a tradition of religious dances. There are still religious dances today, and there have been quite a number of studies of such dances up to the present in various parts of Europe within which the so-called dancing mania fits. Thirdly, the dance frenzy has elements of the kind found in the revival mentioned above. Fourthly, one cannnot overlook the possible presence in such groups of choreics and of frauds, and I think one has to keep in mind at all times that such dancing groups are not necessarily homogeneous. Finally, these were not "crazes" or "manias." Some individuals may have been psychotic. Parenthetically, I wish to emphasize that what I deal with and what I present are anecdotal materials, and I have no apologies for this at all. I think one can learn a great deal from these materials. Peter Cartwright, one of the Kentucky revivalists, points out in his memoirs that a number of individuals became psychotic in the course of the revivals. Not everybody became psychotic, and I think here again we have a point of interest that might be followed up: in such a situation, who breaks down—who, in a sense, is predisposed to psychosis and who is not? We come up against some of the questions that we have been dealing with before.

Then these dance frenzies are not unlike some aspects of millenarian movements which flourish best in times of extraordinary social ferment. The participants may exhibit behavior which becomes ecstatic to the point where observers describe it as mass hysteria.

For example, in the 17th century England quite a number of the extreme groups of the Puritan Party exhibited behavior of this kind. Such phenomena may be considered, and this is an hypothesis that I present quite firmly, as necessary social devices for generating the superhuman efforts needed to change current conditions. I think one has to look at some of these phenomena as not necessarily evil or pathological in and of themselves, but even as useful under certain conditions.

Here we come again to the point that I have raised before, the need, in dealing with such global terms, to specify precisely what we are talking about, under what conditions and at what point. In a sense this is not very different from Dr. Gruenberg's point about checking with some kind of mechanism that will enable one to indicate precisely the conditions under which one is operating.

For example, just to cite something that has nothing to do with epidemiology, but in which I think one can again get an inkling of what goes on, Yeats in his poem on the Easter Rising of 1916 says

> A drunken vainglorious lout.
> . . . . . .
> . . . has been changed in his turn,
> Transformed utterly:
> A terrible beauty is born. (12)

This feeling of utter change is one which I think is quite relevant, because it may lead under other conditions to the disillusionment that occurs after such superhuman efforts, and here too the culture is necessarily involved. An interesting instance of this is the book, THE NEW CLASS (3) written by Milovan Djilas, the Yugoslavian communist who was jailed for his opinions. His deflation, in a sense, is very obvious as one reads the book, and he is now on the downward side of this curve of elation and deflation.

Another point on the role of the culture in producing these phenomena is actual learning. Dr. Gruenberg has dealt with some of this in his article on "Socially Shared Psychopathology" (4), which I have found extremely useful. I would like to cite, however, another instance.

Charcot, in the presentation of his *grande hystérie* very definitely taught his subjects to produce the phenomena. As one reads the records it becomes obvious that here within a definite cultural context, namely, the clinic of the Paris School, he was training hysterics, if you will, so that they could perform beautifully. The same thing occurs, for example, in the famous case of Urbain Grandier in 17th century France, which Aldous Huxley has written up so well in a very entertaining volume. For those who have not read it, it is called, THE DEVILS OF LOUDUN (8). In this case, too, we have a situation in which a number of nuns in a convent were taught to

enter into possessive states. They were told, not directly, but indirectly and by various cues, what to do, and they did it. The Salem witch trials exhibit the same phenomena. In consequence I think one can state quite explicitly—subject, of course, to refinement of the proposition—that cultures *do* produce pathological phenomena and states. They will not produce them all in the same way. Nor am I sure whether they will produce all of them.

I have been talking here about dissociative reactions. This may not apply, let us say, to psychosis; and I think here we have to recognize another point, that global expectations, just as global concepts, do not always function well. One has to break them down. The expectations have to be specified much more precisely.

The second point concerns culture and personality types. Here I care only to remark that we are dealing with an attempt to develop personality types with ideal type concepts, and as all of us who have dealt with ideal types know, this tool suffers from a number of defects. An interesting recent discussion of this problem is to be found in Barbara Wootton's SOCIAL SCIENCE AND SOCIAL PATHOLOGY (11), where she treats the relationship between psychiatric theories and juvenile delinquency and other aspects of crime.

The third point deals with culture as making it possible for psychopathological individuals to enter into certain roles, and this merits a little bit more time. For example, in ancient history prophets and diviners were quite common. Whether these individuals were mentally ill or not is a moot question. However, in more recent periods there are records of such individuals who have actually in times of stress been able to occupy positions and exhibit behavior which certainly falls within our area of concern.

An interesting one occurred in England in the middle of the 17th century. This is the case of Solomon Eccles, who in plague-stricken London of 1665, walked about naked with a dish of fire and brimstone on his head, prophesying woe. He forecast a universal conflagration for the following year. While of course London was destroyed, the world did survive, and he vanished. Eccles was accepted because the society of which he was a part was no stranger to persons of this type—to prophets of woe with odd behavior. They had the Ranters, Fifth Monarchy men, and other groups.

However, coming much closer to our time we find the example of Antonio Conselheiro in Brazil. Antonio "The Counselor" estab-

lished a New Zion at Canudos, in the backwoods of the state of Bahia to which the credulous flocked. The disorders becoming too much for the state militia, the Brazilian Army was despatched, only to suffer a complete rout in 1896. A second army group, after a lengthy and bloody seige which saw all of the men, and most of the women and elder children of New Zion fight to the death, finally restored order to the backlands of Brazil. As one reads the description of Antonio, both in the medical literature as well as in the book by Euclides da Cunha (1) it is quite obvious that he was a man with a religious mania. Just what the exact clinical nature of his illness was it is not easy to say. But certainly given a situation in Brazil very much like the backwoods of the United States in 1800, given a population living under severe conditions, given a population that would like something better, a man who comes along and promises them all sorts of things is obviously in the position to occupy a place of leadership, plus the fact that there have been other cases of this kind in history, both in Brazil and elsewhere.

There is, of course, the famous case of Johann Bockelson of Leyden, who became the King of the Anabaptists at Münster in the 16th century, and eventually reached the stage at which he instituted in his kingdom all kinds of new social institutions, including polygamy. Bockelson tended to lose contact with his environment by rebuking, punishing, and stopping all kinds of criticism. Recently Dr. Gruenberg, in discussing this matter, raised the point, which I think is relevant here, as to the extent to which the culture impedes feedback from various aspects of the community to the person who is the leader. In this sense, if I interpret him correctly, it makes it impossible for the individual to test reality and may predispose him, or make it possible for a predisposed individual, to suffer some sort of psychopathological condition.

The matter of child-rearing practices I think has been stressed considerably. Orlansky (9) and more recently the articles by Pinneau (10) on the work of Spitz, have indicated the holes and the gaps that exist in this literature. I believe the comments yesterday by Dr. Carstairs on Bowlby are sufficient at the moment.

As to the matter of stress in culture, this is another point at which one may discuss the role of culture. Here we enter the area where we descend from the level of the societal to the organismic and the organ systems. I shall emphasize a point that I have made elsewhere

and earlier, namely, the need for working back and forth between various levels. I don't think one can stay on the epidemiologic level alone or on the societal level alone or whatever other level alone. I think at various points there has to be a contact between these levels. How one establishes it becomes a matter of methodology, plus a matter of how one classifies cultures or societies of various kinds or various other systems that I am certain are necessary in this area.

I would like to cite to you one or two studies which bear on this point. One is a report by S. R. Hill which includes studies on the adrenal cortical stress in man (6). The investigators took two rowing teams at Harvard for 1953 and 1954 and studied them. Their metabolic responses, as well as their psychological responses were examined in various ways, both before and after a race. The 1953 crew, as did the 1954 crew, responded very variably before the race, both in a metabolic sense as well as in a psychological sense. During the race, the 1953 crew tended to become more uniform in terms of metabolic response. The 1954 crew did not. Interestingly enough, the 1953 crew won the important annual race while the 1954 crew lost the race.

I think there is an interesting hypothesis here as to a type of research which, in my opinion, has not been sufficiently explored. It might even be attempted on an epidemiologic basis if one had a large enough population. There are, of course, difficulties in this sort of thing, and I am willing to admit them.

The other point raised by Dr. Leighton—the matter of inbreeding and so on—has been touched on before by Dr. Böök in his paper. I think it might be said, however, that we can actually trace a neurologic condition which has certain psychotic components. Using Huntington's chorea, as an example, we can follow how the disease was brought over to Long Island where Huntington lived and where he found his first case, and how he traced the whole genealogy of the disease in the involved families. Also, one can see as one goes back into the history of this area how some of the choreics were occasionally mistaken for witches and were involved in witch trials, and how some of them got involved in other things that I have mentioned earlier, particularly the revivalistic situation.

Finally, I shall end on two notes. One relates to the point that Dr. Leighton raised about systems of classification. I have indicated, for example, certain general approaches. With regard to cultural

classifications where we have great difficulty, I feel that there may be a value in going back to the earlier Hobhouse classification of various peoples (7). Using material artifacts and combining them with an ideologic classification, we can establish material-ideologic areas. This system might be related to another system, which might begin with an ecumenical type of culture, namely, a culture spread over an extremely large area, say the Graeco-Roman culture, or the European-American culture. This is then broken down into what one might call a national and regional variant of this culture. For example, within the European-American, we have the United States, France, Germany, and a number of other countries which certainly differ within this general context. Then within the national, one can have a regional classification or level, and beneath that a local level. Of course, one can make any subdivisions of such a classification as are necessary to deal with the available data. I have attempted to use this approach in certain studies that I am doing at the present time, and while I am not sure how useful it is going to be, I would like to advance the suggestion for discussion.

The last point relates to the cultural bias of the investigator. This is a point which, while it was touched on, requires, I think, much more stress and emphasis. I would like to call your attention, for example, to the earlier studies on immigration and migrants, and to the fact that many of the investigators had very definite biases against the immigrants. I cite, for example, an argument for restriction after the First World War. It came when social scientists produced statistics on the caliber of American soldiers—information derived from psychological tests designed to measure the intellectual capacity or inherited ability of the young men—which seemed to prove that 46 per cent of the foreign-born soldiers had a very low grade of intelligence. This supported the basic restrictionist contention that the new "immigrant groups" were altogether (aside from the factor of literacy) inferior-minded. Again, a distinguished scientist in 1921 pointed out that the low mentality prevailing among most of the foreign-born led them into pauperism, crime, sex offenses, and dependency; that the different forms of crime already associated with each ethnic group in the country were fixed by heredity.

This kind of thing in subtler form still exists at the present time. I think it is amusing, and at the same time thought-provoking, that we may be doing the same thing unwittingly or wittingly: culture

does have an impact on how we diagnose, or where we recognize mental illness, and on that note I would like to stop.

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SUMMARY OF DISCUSSION

(1) The suggestion that reality testing could be used as a yardstick of mental disorder for cross cultural studies was questioned. Since most people carry around with them their own concept of reality, the adequacy and relevancy of this yardstick depended upon the particular situation being examined. While various objective measures—such as the efficiency of economic productivity—do exist, these are not particularly relevant to the investigation of the distribution of psychopathology. Where other more "relevant"

measures exist, these tend to be relevant only within the observer's framework and are not necessarily relevant to the situation actually at hand. In reply, it was pointed out that to appraise a person's reality-testing required a knowledge of his culture as a prerequisite. Thus the Moroccan Jewish immigrant to Israel who frequently refused hospitalization and who, if brought into the hospital refused to sleep in a bed, lying instead on the floor, was reacting to the belief that white sheets were shrouds and the hospital bed a death bed. However, when the beds were made up with green sheets, the problem was overcome, and the patient was grateful and happy to receive the medical care he needed. Episodes such as these offered special opportunities to study defects in "reality-testing" on the part of the health professions as well as to correct their erroneous belief that such defects lay with their patients.

If the observer is to pass judgment on the reality-testing of those observed, it is essential to establish the frames of reference of both the observer and of the individuals or groups under study; to get to know what people think, what they do, and why. The concept is essential, since not only can the frameworks be different, but certain elements can be totally lacking; that is, the framework of the group being studied may not encompass the whole range of the "reality" apparent to an outside observer. The attempt of a backwoods' group, the Lazzaretti, to found a "New Jerusalem" in Tuscany during the 1850's or 1860's was cited as an example. The fact that this group might have been behaving peculiarly within the framework of a well-read, well-traveled visitor of the period, would not necessarily mean that they were not acting rationally within their own framework. There were thus two elements—two frames of reference—that had to be brought together before judgment on reality-testing could be passed: "The other fellow's and mine."

(2) It cannot be assumed that all mental disorders are the same everywhere, or even the same in the same place. They might take on different symptom forms, as the dissociative reactions obviously do, or an illness might not even be recognized as a distinct entity until a certain point in time as, for example, pellagra in the 18th century. While such exotic conditions as lâtah or koro or arctic hysteria could all be classified under one general term, it is important to know what they mean within their own specific cultural contexts. Thus, they might not be regarded as pathological but as quite normal behavior,

because everyone had it, or because everyone who had it was accepted by the community. And yet, from the Western point of view these were pathological disorders. Given separate categorization of mental disorders and cultural factors, there might appear to be a basis for comparison between cultures. But in actual experience mental disorders could not be categorized independently of cultural factors.

(3) Another point dealt with the distinction between normal and pathological psychology. The types of behavior that had been discussed in Point (2) above, however bizarre they might appear could, perhaps, confer advantages or be the realizations of some adaptive capacities of human beings in certain kinds of situations. Thus people who went through dissociative reactions often felt better afterwards. Mystics, for example, generally derived a sense of well-being from their special experiences.

Whirling dervishes, by employing perfectly standardized ritualistic methods for inducing a dissociated state (such as breathing rhythms), were able to pass daggers through cheek and tongue. Their climax was a mystical experience and release; the kind of conversion phenomenon discussed by Stanley Hall.

Dr. Rosen's description of the Great Revival in Kentucky was exactly paralleled by one which recounts Billy Graham's recent meetings in New York. Some participants in the discussion were sure this did not involve psychopathology though such events might be seeded with pathological individuals and frauds.

Histories of churches showed a pattern in the development of these phenomena. Beginning with various types of release mechanisms which appeared to arise out of the insecurities of the population (such as frontier life or very low socio-economic standing) these traits disappeared as the churches became older and more solidly established. This, for example, was the history of the Methodists in the Midwest.

Were such an event as the current (1959) steel strike to continue long enough, it would be interesting to speculate about what might arise to take up the tension. Perhaps religious revivals are alternatives to revolution. Whether revivals might be considered healthier than revolutions is a matter of value judgment.

(4) Do such episodes as the Dancing Manias simply compress cases in the long-run occurrence of psychosis? Do they add cases to the long-run total? Or do they merely precipitate cases earlier than

would otherwise have occurred. It was pointed out that while mortality rates in New York City rise during heat waves they are followed by drops below normal; the heat apparently causing the chronically ill to die a little earlier than they would have otherwise. This question applies not only to phenomena like the Dancing Manias but to any social or cultural factor. Such factors might either add to the actual over-all risk, or only shift the risk to an earlier time.

(5) There seems to be no clearly demonstrated instance of either a cultural or a social factor being known to be a predisposing factor in mental illness. This is true whether the category used was a broad one, such as social disorganization or social isolation, or a far more limited one. The absence of clear-cut evidence does not show that the hypothesis is incorrect but only that it has not been demonstrated even once.

Twin studies give good evidence for genetic influence; on brain damage, there is quite definite evidence. Such evidence helps the investigator by serving as a starting point and as a point to fall back on. The absence of such evidence in the social and cultural areas regarding effects on the prevalence of mental disorder is a serious lack. The ultimate finding may be that culture is only important in determining a peculiar mode of expression and is not in itself a basic factor. The effect of culture on mental disorder may be a precipitating cause. Perhaps culture increases the risk of a particular set of symptoms of disordered functioning in people who would have developed a different form in another culture. If so, the general level of all types of symptom groups taken together would not be affected by variations in the type of culture.

The kind of person who shows different patterns of unusual action at different times in his life was suggested as an example. Thus in Britain there were young men who, starting as enthusiastic Oxford Groupers in college, became Communists, moved through a socialist phase, and ended up flirting with ultra-nationalism of one kind or another. These people were reacting to the changing social and intellectual environment of the times, and while each phase could be described differently, they represented but a single group of people. Perhaps this same sort of variation in overt behavior will be found in people with mental disorders in different social or cultural environment.

The view that culture is only important as determining the par-

ticular mode of expression of mental disorder might seem depressive and nihilistic, but it would be a great help to have it tested objectively.

DR. LEIGHTON: Let me take up a few of the scattered points that have been raised and then try to pull together a couple of synthesizing notions.

I agree with Dr. Rosen's point about the importance of the cultural context in making an assessment of psychiatric disorder, but I would underscore this as a technical matter, over and above its being a question of steeping in another culture. Steeping alone is not enough. During the war, I had occasion to observe "Old Japan Hands" in action as advisers to the intelligence services, and found that their impressions were often inferior to those based on naïve but systematic analysis of data.

Speaking of Japan reminds me of earlier reference at this meeting to the Dancing Manias. I should like to mention in passing that they occurred more recently in Japan than in Europe.

The point brought out in the previous discussion on migration—namely, who migrates—is worthy of more attention. In our studies in Nova Scotia we have by chance been dealing with a place that exports people. A prevailing view of its residents is that the smart ones get out and only the stupid, or those with personalities somewhat handicapped emotionally, stay. My impressions would lead me to doubt this. It would be interesting to reflect on what kind of a country the United States or Australia would be if this kind of generalization about migrants had universal validity. The Nova Scotian studies suggest that the reasons for staying behind are as various as the reasons for migrating, and they can be lined up as much on the side of assets of personality as on the side of liabilities.

In answer to the question raised in Point (5)—whether one can fall back on something solid methodologically: we do not yet have anything as useful as the twin approach in genetics, even allowing for its disadvantages. There have been, however, a number of worthy attempts such as predicting from the child-rearing practices what kind of personalities, and what kind of tendency to breakdown, will be found in the adult population. This approach, however, has always struck me as being a good deal like looking up

the answers in a book of arithmetic and then working out the problem afterwards. One usually starts the analysis of child-rearing with some impression of the prevailing personality characteristics of people in the culture under investigation.

There is a fairly extensive modern study going on now, as you probably know, under the guidance of Whiting, which is trying to analyze and compare data that has been collected from many cultures.*

A question which deserves a whole meeting to itself concerns what it is we are gonig to count. See Point (2). Let me hazard a few sweeping generalizations.

One is that no existing form of diagnosis is usable for the purposes we have been discussing. This applies not only to hospital records, but to what would result if the investigator went out into the field and tried to make his own diagnosis on a sample. He couldn't use any of the systems of diagnosis that are currently employed in psychiatric clinics, private practice, or anywhere else. Some modifications would have to be worked out.

One has to get rid of the built-in etiological pre-conceptions that exist in most diagnostic acts. Where studies are concerned with exploring the etiological influences of cultural factors, the psychiatric phenomena for study have to be defined in terms of symptom patterns. The question of whether they are pathological or not should be set aside. In short, one has to study the distribution of selected types of human patterns, and only later ask what the functional effect and consequences of these are. The determination of pathology is the last thing to be done rather than the first.

Admittedly, however, the selection of which patterns one is going to follow in this kind of an epidemiological study is based on one's conception of what the character of psychiatric disorders is—on what is seen commonly in psychiatric clinics. This is a very complicated, although not quite hopeless, subject. The difficulties of cultural relativity also tend to look worse when one is thinking about them in the abstract than they do when one is trying to compare the people of two different cultures.

The crisis situations that Dr. Rosen was talking about can be viewed as an extension in time of the kind of thing Dr. Hughes and

* Human Relations Area File, Yale University.

I tried to describe when we mentioned havens like North Beach, Greenwich Village and religious groups. There may be more of those at one period than at another.

Turning now to a more general level of discussion, it seems to me that there are two approaches to the problem of evidence regarding the influence of cultural factors. One is through successive approximations. I visualize here the comparing of two cultures and finding that some kinds of symptom patterns have a statistically significant difference in frequency. With successive stages of refinement in criteria and methods, the precise cultural factors associated with these differences could, with reasonable hope, be ferreted out.

The other approach is that stressed by Dr. Rosen in his discussion: One can pick socio-cultural situations which one can expect, on the basis of psychiatric theory, to be loaded with a tendency to produce psychiatric disorder. Religious revivals might be one such, but there are obviously many others that would bear investigation: broken homes and upward mobility in the socio-economic system are others. These could be examined to see whether or not there is in fact a higher association of psychiatric disorder, and then why some people, in spite of these adverse situations, do not develop symptoms, and so on. The acculturation process, social change, low socio-economic status, and much else is susceptible of this kind of treatment.

I think these two sorts of approaches will have to be related to each other as the field progresses. Perhaps the first is where you get ideas for target areas, and then the second is what you do in order to find out more about how processes move along through time. It seems to me this fits with Dr. Densen's idea, that there needs to be a relationship between the extensive study and the intensive study.

Let us look now at the problem of classifying cultures. See Point (2). This is a topic that I also feel would be worthy of a whole meeting; however there are some points that can be made briefly. We need, of course, a system. We need a way of classifying which is workable and objective in the sense that different observers would be able to draw the same conclusions when operating independently of each other.

But this is not enough. The system has to be related to the character of psychiatric disorder. The little we know about psychodynamic processes has to be taken into account, so that the system of

categories for cultures will have a probability of showing significant relationships to psychiatric disorder.

It would be easy to develop systems that would organize cultures into categories that had reasonably clean margins, but it is not easy to do this and carve nature at the joints which separate the factors significant in fostering psychiatric disorder from those that are not. It is Brownowski, I believe, who has pointed out in connection with the classification of species, that Linnaeus could have developed a clearer and more measurable system if he had classified flowers according to color or weight or size. The fact, however, that he hit upon pattern as the basis for classification meant that he carved nature at the joints, which makes possible the development of concepts and evidence regarding evolution. The simpler, more definite and measurable methods would not have had this value.

DR. MACMAHON: Thank you very much, Dr. Leighton. I have been trying to get in a quotation ever since we were talking about core schizophrenia, and you have let me manage it very nicely. It is by John Stuart Mill. He is describing an entity, "It is a piece of barbarous lath invented by school teachers and taken over by the logicians to stop a leak in their terminology." That closes the scientific session, if that is the word for it.

DR. GRUENBERG: I just want to express my thanks to all of you for the hard work that has been done in preparing for the meeting. While I suppose I should take particular note of those who prepared the papers, I must also voice thanks to those who read them so very carefully before the meeting. I have never seen a meeting done this way before—where there were no formal presentations, and where the group which assembled had read a common body of material before the discussion. It was an experiment, and my own evaluation is that the experiment has been a success. That it is so is, I think, due to the conscientious work that all of you have put into it, for which I am very grateful, and I thank you all.

DR. MACMAHON: I think it would be appropriate for me on behalf of the participants to thank the Milbank Memorial Fund for the opportunity of participating in the meeting. It has been an extremely interesting one.