

Cultures as a Causative of Mental Disorder

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A REVIEW OF 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

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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 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, Kwa-kiutl, 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 individual 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. Physiological 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 symptoms 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 us¹ 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 Prestigious 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 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

¹AHL

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 earlier.

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 indicate 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 overemphasis 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 3 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 Belgian 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 trans-cultural 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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