American Handbook of Psychiatry

A REVIEW OF TRANSCULTURAL PSYCHIATRY

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TRANSCULTURAL PSYCHIATRY is the Study of the effects of culture on the pattern, frequency, and management of psychiatric disorders. The expression is roughly synonymous with comparative, or cross-cultural, psychiatry or with ethnopsychiatry. Related areas include the study of the effects of culture on personality and on normal psychological processes: The former has been largely the province of anthropologists with psychoanalytic interests; the latter, which is of more recent vintage and includes the study of cultural effects on perception, cognition, intelligence, motivation, and the like, is being developed largely by psychologists.

Historical Development

Psychiatrists have always had at least a desultory interest in the possible effects of culture on the illnesses they treated. One of their early preoccupations was with the question of the relation between mental illness and civilization; most authors, including Esquirol, Tuke, and Maudsley, held an unrealistically rosy view of primitive life and assumed that mental illness was the price of progress.

> We seldom meet with insanity among the savage tribes of men; not one of our African travelers remark their having seen a single madman. Among the slaves of the West Indies it very rarely occurs; and, as we have elsewhere shown from actual returns, the contented peasantry of the Welsh mountains, the western Hebrides, and the wilds of Ireland are

> almost free from this complaint. It is by the over exertion of the mind, in overworking its instruments so as to weaken them . . . that insanity may be said to take place in a great number of instances.

Before the effects of the cultural dimension could make a significant impact on psychiatric theory, psychiatrists had to be exposed to significant numbers of mentally ill from different cultures; and for the effect of culture to be most visible, a high degree of contrast between the cultural background of the patient and the physician was required.

It was perhaps because of the lack of contrast that American psychiatry's first exposure to cultural variety was not too enlightening. Between 1839 and 1844 some 400,000 European immigrants flocked into the United States. Superintendents of already crowded mental hospitals noted with alarm the flood of "pauper insane," mainly Irish and German peasants. Most seemed to regard the immigrant as a kind of inferior American. The intellectual harvest of the contact was scant and did not extend beyond comments about filthy habits, refusal to work, and lower level of intelligence. There was also some speculation about the Irish peasants' greater susceptibility to mental disorder and resistance to treatment.

Other circumstances proved more productive. Toward the end of the nineteenth century, the colonizing European powers began to build and staff lunatic asylums in their holdings in Africa, the Caribbean, and Southeast Asia. There was much greater contrast between the culture of the physician and

the patients, and a number of reports of varying quality began to appear in the psychiatric journals of the mother countries.

In spite of their lack of anthropological and epidemiological sophistication and their often condescending attitudes toward the natives, these early physicians made observations and raised questions that continue to be the concern of transcultural psychiatry. They described unusual symptom patterns, such as *latah* and *koro,* and questioned whether some disorders were peculiar to certain cultures; they noted that psychotic episodes were often shorter lived than was typical in Europe and that intense depressions and suicides were less frequent; they commented on the apparent importance of Westernization of indigenes as a factor in producing disorder; they speculated about the usefulness of the indigenous healer in the treatment of psychiatric illness.

A major stimulus occurred in the 1930s when Freud's ideas began to make themselves felt in this area. Apart from his own provocative excursions into anthropology in *Totem and Taboo* (1912) and *Civilization and Its Discontents* (1930), many of his basic insights were highly relevant to transcultural psychiatry: his emphasis on parent-child relationships in shaping personality and causing disorder suggested that cultures with grossly different patterns of child rearing might generate different psychiatric phenomena; his demonstration that nonrational behavior and symptoms

could have intelligible meanings and defensive functions opened up whole new areas for exploration not only of psychiatric disorders but also of cultural institutions, such as religions and ceremonial behavior. Freud's work inspired colonial psychiatrists to broaden their horizons; even more important, his work was a major force in drawing anthropology into closer contact with problems of personality and psychopathology. The result was a major shift in the kind of data collected in the field. Anthropologists began to record detailed descriptions of child-rearing practices, to collect biographical studies of individuals from non-Western cultures, and to investigate specific cases of psychoses and neuroses among the peoples they studied. With or without psychiatric assistance, attempts were also made to relate child-rearing practices to adult personality and to articulate psychiatric disorders with the mythology, conflicts, and modes of life of the people among whom the disorders were found. Sapir was a major influence in promoting anthropological interest in psychiatry; not only did he recommend the works of Freud, Abraham, Ferenczi, and Jung to his students, but he actively encouraged them to undergo psychoanalysis.

A final important factor in the development of transcultural psychiatry has been the appearance of Western trained psychiatrists who are themselves members of non-Western societies. Because of their intimate knowledge of their own cultures they have been able to correct biased impressions of foreign observers and to provide cultural explanations for previously ill-

understood syndromes. For example, many Western authors had been impressed by the similarity of the belief systems of many primitive groups to the delusions of schizophrenics: The notion that witches and sorcerers can damage individuals from afar seemed very like the ideas of influence of psychotics; the belief that incantations can produce rain or energize medicinal plants was equated with ideas of omnipotence in schizophrenic thinking. Lambo and others, defending themselves against what they regard as a denigration of the African native population, vehemently attacked this view. Lambo contended that magical beliefs play an integrative function in his own traditional Yoruba culture and cannot be interpreted as in any significant way comparable to the alienating delusions of a schizophrenic. Lambo's position is consistent with that of many anthropologists.

Several comprehensive reviews of transcultural literature have appeared during the past thirty years. Today, works on the subject appear with increasing frequency and two periodicals are specifically devoted to these studies: *Psychopathologie africaine,* published in Dakar, and *Transcultural Psychiatric Research Review,* published in Montreal.

Culture and Personality

Certain drives are common to all men, although variations in degree and quality do occur. For a prolonged period all infants are in a state of complete

dependence on their mothers. Gradually they move from their symbiotic relationship with her to a state of self-differentiation: I is separated from non-I. Gradually, too, with physical growth, shifts take place in zone predominance regarding mouth, anus, and genitals, though this zonal orientation is less rigidly delineated than is often supposed. Type and character of child rearing depend not only on individual variations of mothers but also reflect sociocultural climate. Variations in early mother-child relationships may produce a variety of effects in the adult. For example, in many primitive societies babies are breastfed for two years or more, close cutaneous contact is maintained between mother and child for a prolonged period, and toilet training by Western standards is lax. It has been suggested that the protracted child-mother intimacy (Collomb's extrauterine gestation) may account for the Western primitive differences in demarcation of ego boundaries, instinct, and impulse control and a variety of cognitive operations; perhaps the lack of emphasis on toilet training has its reverberations in absence of sphincter morality, disregard for time, and want of restraint in the expression of aggressiveness.

Several psychoanalytically oriented studies suggested that ego development, preferred ego defense mechanisms, superego functions, object relationships, and reality appraisal differ significantly between members of primitive cultures and members of technological cultures. As regards ego defense mechanisms, it has been found that members of primitive cultures

are more apt to deny their objectionable impulses, project them onto witches and sorcerers, or to regress, under stress, to infantile modes of behavior than are members of technologically advanced cultures who unconsciously prefer such ego defense mechanisms as suppression, repression, reaction formation, and sublimation.

But as has already been noted, many of these relationships between child-rearing practices and personality have been challenged, especially by non-Western psychiatrists and anthropologists. When a Yoruba mother attributes the illness of her son to bewitchment by her cowife, the questions may well be asked: Is the mother's mode of thinking related to her own experiences as a child, to the fact that all Yoruba think that way, to the absence of effective police control in the Yoruba culture, or could it be that this manner of thinking is functional for the culture in providing an answer to why the child is sick and offering clear methods for attempting to cure him?

Many attempts have been made to arrive at a suitable phrasing of the complex processes whereby a given culture arrives at its specific social institutions, belief systems, and modal personalities. Kardiner, who has worked closely with several prominent anthropologists (Mead, Linton, DuBois, and others), provided the basis for the following generalizations:

1. Social evolution obviously occurs but does not follow a unilinear course. Hence each society must be studied as an entity in

itself.

2. In order to understand the institutions and beliefs of a society, one must reconstruct the problems of adaptation the society has faced (for example, the adaptations to climatic, subsistence, and territorial problems as well as pressures from neighboring groups).

3. There are often many institutional methods for solving a given adaptational problem. For example, in some communities in danger of outstripping their food supply, the solution might be female infanticide (Marquesas island) or institutionalized abortion (island of Yap).

4. Social institutions are the patterned relationships that accommodate the individual to the human and natural environment.

5. Not all institutional patterns and belief systems are equally successful in adaptive power, and some may be disastrous in generating high rates of individual stress or psychopathology. Some patterns that were once functional may subsequently become dysfunctional. For example, on the island of Yap, where there used to be population pressures, today, owing to institutionalized abortion, the population has decreased alarmingly.

6. The interaction of individuals in society creates new institutions: Some promote cooperation; others stimulate anxiety and rage. The success of a society depends on a balance in favor of the former.

Psychocultural Stress

No culture has succeeded in solving its adaptational problems without some kind and degree of coercion. Child-rearing practices, initiation rituals, some form of apprenticeship or schooling, laws, and taboos are common techniques to compel individuals to follow social norms and rules. These techniques vary from extreme permissiveness to harsh severity. Invariably, at one time or another during the individual's life, some of these constraints will cause frustration. The negative effect of tensions arising from these constraints is ameliorated by training to tolerate them, by cultural mechanisms that serve as safety valves, by institutionalized niches for deviants and marginal individuals, and by psychological compensations for culturally standardized behavior. A few examples may be given. Most Americans have learned to endure tension arising from competition and from a much greater degree of social isolation than exists in most other cultures. Conversely, among the Pueblo Indians, most individuals have acquired the capacity to tolerate tensions arising from constant immersion in the extended family and other groups that allow little scope for individuality. In other societies, ritual trances, bullfights, and drinking provide permissible outlets for cultural tensions while priesthood or shamanism may serve as a refuge for deviant individuals who find in these roles much gratification and even power over their fellow countrymen.

Nevertheless, such mechanisms can only mitigate cultural stress factors. They do not eliminate them. This very fact, added to numerous evidences that mental illness is found in all human societies, tends to indicate that culture per se (envisioned as a mold imposed on human drives and as a constellation of stimuli for human thought, sentiment, and behavior) universally generates significant psychological and even biological tensions. Everywhere some individuals become mentally ill, whereas others become deviants, delinquents, or reformers.

Psychocultural stress factors may be divided into three broad categories: cultural content, social organization, and sociocultural change.

Cultural Content

Basically, the relationship between cultural content and mental disease lies in the degree to which some cultural elements create tension between individuals, or generate anxiety within them.

Taboos

Prominent among these elements is what may be called "cultural deprivation of basic gratifications." Such deprivation exists when the rules and taboos imposed by culture on a population or on some social groups within it become so excessive that they frustrate essential human needs. Such

taboos may be related to food, aggression, sex, personal initiative, and political or religious authority. For instance, when a culture prescribes an excessive load of taboos to women without due compensations in terms of prestige, as is the case in some North African societies, it has been shown that mental disorders in women increase in frequency. However, the pathogenic effect of taboos should not be overrated. Their amount and rigidity predispose to mental disease not by themselves but rather in interrelation with other cultural elements, such as values.

Value Saturation

No two individuals adopt the values of their society in an identical manner. While most individuals are reasonably guided in their thoughts, attitudes, and behavior by cultural values, some individuals are unable to accept them, whereas others become imbued by them almost to the extent of intoxication. This phenomenon may be called "value saturation." A typical example is that of an American, who though lacking all the intellectual, emotional, and material qualities necessary to become a good businessman, will devote his whole life to the vain pursuit of success. In this case, psychological tension may assume such proportions that mental disease ensues. Probably some cultures and subcultures tend to produce more saturation than others. Germany's collective obsession with racial purity culminated in the tragedy of the extermination camps.

In most cases of value saturation, it is not easy to draw the line between normal and abnormal. For instance, A. F. C. Wallace cited the case of Aharihon, an Onondaga war captive who was the idol of Iroquois youth because they could recognize in him the ego ideal of their culture. However, Aharihon had embodied the Iroquois model of manhood, especially the virtues of bravery and cruelty, to such an extreme that he could also have been considered a killer.

Value Polymorphism

Value polymorphism refers to the coexistence, within the same cultural system or within the same individual, of values that are antagonistic. There are three major aspects of value polymorphism: (1) It may encompass a culture as a whole. This occurs generally in complex societies where an individual may be confronted with different ideologies, moral norms, and religious dogmas. (2) Another aspect of value polymorphism is related to cultural discontinuity and to role replacement. The passage from the status of son to the status of father entails a discontinuity in terms of values and roles, for example, from dependence on others to the responsibility for others. This, of course, is the natural order of things. However, when a culture does not provide proper and clear strategies, such as *rites de passage,* for these changes in the individual's life, or when the transitions and the roles themselves are ambiguously defined, the individual may find himself

confronted with contradictory values, unable to choose those that could introduce him to his future statuses. The passage from adolescence to adulthood in Occidental cultures is a good example. (3) The third aspect of value polymorphism is the excessive exposure of individuals to simultaneous statuses. All human beings have simultaneous statuses: Most adult females must be good daughters, good mothers, good wives, good daughters-in-law, and so on. Generally such status pluralism does not create excessive tensions. However, it can happen, especially in societies dominated by value saturation, that some of these statuses become incompatible. For instance, the business executive may have so much responsibility as to interfere with gratifications derived from his other roles as father, husband, and friend. Some cultures have taken care of value polymorphism by strategies to reduce anxiety. For instance, the Masai of Africa forbid young men engaged in military training and activities to marry, but they permit them to have sexual relations with young unmarried girls.

Role Deprivation

The opposite of value polymorphism is role deprivation, that is, the withdrawal of culturally and psychologically significant statuses and roles from some categories of individuals. The most extreme case of role deprivation is the ritual execution or exiling of individuals guilty of some taboo violation, such as incest or giving birth to twins. Other examples of role

deprivation are the enforced retirement of the aged in Occidental societies and their relegation to uselessness culminating in killing in some primitive societies, such as the Eskimos and some Australian tribes, and the discrimination against some minority groups, such as Negroes in North America, and inferior castes in India and Japan.

Wallace cited the case of the Seneca who, when they realized their socioeconomic situation and their white neighbor's contempt for their language and culture, became quasi-pathological: "Many became drunkards; the fear of witches increased; squabbling factions were unable to achieve a common policy." A very similar reaction occurred in New Guinea when the Aborigines realized that they had actually been conquered. Heavy drinking was also among the quasi-pathological reactions observed among them. While the Seneca, after their first reactions, developed a revitalization movement where old and new virtues were emphasized, the New Guineans devised the famous cargo cult. Examples of similar reactions are plentiful and well documented by Lanternari.

Sentiments

Another sociocultural factor linked to mental disease is the culture-bound system of sentiments that prevails in a particular society. Some cultures have been described, often too sweepingly, as being generally

characterized by jealousy, megalomania, fear of spirits, and fear of people. For instance, in Ghana, according to Field, fear of sorcery and of evil spirits is so common and so intense that everyone is suspicious of everyone else. Among the aborigines of New Guinea, "both fear and aggression are deliberately fostered." There is good reason to believe that the more intense such culture-bound sentiments are in a society, the more widespread will be mental illness.

Social Organization

Two aspects of social organization deserve special attention regarding their relevance to mental illness: anomie and rigidity.

"Anomie" refers to the lack of integration of social organization and is sometimes used synonymously with social disorganization. A relationship between anomie and increased frequency of mental disorders has been established in Leighton's well-known Stirling County study.

It has been demonstrated that unemployment and poverty in the slums of the big North American cities and migration to urban areas in Africa and South America are associated with high rates of mental illness. However, the correlation between anomie and mental disease is not so simple as may appear because a variety of factors combine in determining anomie and frequency of mental disorders. Recent discussions on possible correlations

between the so-called culture of poverty and mental health have also revealed the complexity of factors involved. Movement of mentally ill persons into slum areas is one such factor. Nonetheless, there is plenty of evidence that lack of education, poverty, ethnic diversity, and especially anomie and migration tend to create tensions because they deprive the individual of significant statuses and gratifying roles (role deprivation) and produce value polymorphism.

The reverse of social disorganization is social rigidity. This term means that the overall social structure of a society has become so inflexible that individuals have no choice but to conform to prescribed social norms. Typically, in small communities dominated by traditional values and by a social structure that imposes on individuals specific statuses and roles, those unable to knuckle down to passive conformance feel so constrained that great emotional tension ensues; they will become marginal, delinquent, or psychologically disturbed. Some of them will move to the cities in the hope of finding proper niches but more often than not they experience anomie and other types of tension.

Sociocultural Change

Much research has been done on the effect of sociocultural change on mental health. Sociocultural change occurs, of course, everywhere, but it

varies in rate and nature according to a complex set of technological, economic, social, and cultural factors.

Sociocultural change does not always produce adverse emotional reactions. Some cultures seem to have a fairly high degree of cultural elasticity that makes them adaptable to new situations and new culture traits; such is the case with the Kamba, a Bantu tribe of East Africa, a society characterized by individualism and structural "looseness." Nor need reactions to contact necessarily be pathogenic; reactions to acculturation seem to vary in relation to the cultural patterns that had prevailed among North American Indian tribes before their contacts with white Americans.

However, it has also been demonstrated that sociocultural change due to contacts between different social and cultural groups can be very harmful, although, of course, such psychological damage is not due entirely to cultural change. Other factors, such as low social status and poverty, are also at work. Hallowell's study of the Ojibwa clearly indicates that those Ojibwa who were partly acculturated had regressive personalities. It is also well known that most primitive people living on the fringe of a complex society are subjected to stresses that increase the incidence of mental illness. The plight of colonized people has often been mentioned in that respect. Sociocultural change owing to migration seems to be particularly stressful; it has been observed on all continents. For instance, it would seem that the migration of

Peruvians from small mountain communities to sea level regions engenders physiological stress as well as psychological insecurity.

Factors involved in social change are so numerous and so intertwined that it is almost impossible to pinpoint the specific effect of each one. In brief, it can be concluded that sociocultural change is noxious to mental health, especially if it occurs in combination with one or more of the previously named stress factors, such as anomie, role deprivation, and value polymorphism.

Culture and Psychiatric Disorder

Turning now to the psychiatric implications of the cultural stress factors described above, it should be stated that most psychiatrists subscribe to a pluralistic etiological view of mental disorder. One often neglected dimension of psychiatry is the cultural dimension. This cultural dimension will be dealt with under three headings: symptomatology of mental disorders, the question of the culture-bound syndromes, and frequency of mental disorder.

Symptomatology of Mental Disorders

Much of our information about symptomatology of mental illness in developing countries comes from a highly selected sample, that is, patients admitted to mental hospitals because of grossly disturbed behavior.

Moreover, in many developing countries the mental state of the patient may be influenced by vitamin deficiencies, parasitic infestation, infectious diseases, malnutrition, and other organic factors. To some observers, the clinical manifestations of mental disorders owing to cultural and organic factors are so atypical that Western diagnostic categories hardly apply at all. But most observers stress similarities rather than differences, simply pointing out variations in intensity, duration, verbalized content, and affective coloring of disorders. Occasionally, the differences have seemed so marked as to suggest a different fundamental category of disorder, and these have been called culture-bound syndromes. As more data accumulates, however, the concept of the culture-bound syndrome becomes less acceptable or, at least, is reduced to a play on words.

There is now general agreement that schizophrenia is to be found in all cultures and that the clinical subforms (simple, hebephrenic, catatonic, paranoid) occur everywhere, though in varying frequencies. The alleged rarity of simple schizophrenia in some societies may be owing to the acceptance of low work performance by some communities: Without the work ethic, to be indolent on pathological grounds is not exceptional. States of excitement are not necessarily related to schizophrenia in some cultures. They occur as brief psychogenic episodes and are related to the tendency in some primitive populations to regress massively in response to stress. While chronic schizophrenic catatonic states have become rare in Europe and

America, they are common in India and other Asian countries. The frequency of catatonic stupors in these countries may be due to the teaching both by Hinduism and Buddhism of social and emotional withdrawal as an acceptable mode of reacting to difficulties; the frequency of catatonic rigidity and of negativism in Indian schizophrenics may be due to a traditional passive-aggressive response to a threatening world. By contrast, the maintenance of social contacts in southern Italian schizophrenics, even in advanced stages, has been attributed to their traditional sociability and to their great family solidarity. Observers from both Africa and India agree that paranoid formations in schizophrenic patients under their care are less systematized than in Euro-Americans. It is obvious that varying cultural beliefs mold the content of delusions and hallucinations: An Eskimo who has never heard of Jesus Christ or General de Gaulle can obviously not imagine that he is either of them in his grandiose psychotic ideas; in the African bush an indigenous paranoid patient will accuse a witch of damaging him and will feel persecuted by spirits and not by X-rays, radio, or television. An Austrian psychiatrist studied changes in schizophrenic symptomatology during the last hundred years; comparing the first half century with the second he found that ideas of persecution by God or demons have become infrequent and ideas of being persecuted by material agents more common. According to Japanese investigators, paranoid schizophrenia has increased in Japan since World War II. Since then, in place of delusions regarding the Emperor, paranoid delusions

have concerned themselves increasingly with the United States, the Communist Party, radio, and television.

A global survey carried out at McGill University revealed that symptoms of endogenous depression in its classical form are most commonly found among Europeans, irrespective of where they five. Atypical features have been noted in other cultures. Outstanding among these are the frequency of hypochondriacal ideas, the frequency of persecutory ideas (hallucinations and delusions) in developing countries, and the rarity of suicide and feelings of unworthiness and guilt in, for example, Sub-Saharan Africa.

Feelings of unworthiness and guilt in depressives are most pronounced in Euro-Americans; they also occur in Japanese, Chinese, Indians, and Arabs. Self-accusatory ideas may be concerned with trespasses on morality, on society, or on worship of ancestors or deities. Guilt feelings in depressives are absent in societies in which superego pressures are externalized: Feelings of having sinned can be experienced only if the concept of sin is part of one's religious belief system. Projection of id impulses and of superego censures onto the outer world, so common in developing countries, counteracts feelings of guilt but results in paranoid formations that may mask the depressive picture. As regards hypochondriacal sensations, incapacity to verbalize feelings may account for their frequency in depressed preliterates. It is also possible, as Collomb suggested for the Senegalese, that prolonged

skin contact between mother and child reinforces libidinization of the body and therefore predisposes to pathological body sensations in depressives.

The gross forms of conversion hysteria, such as abasia-astasia, blindness, and deafness have almost vanished in Europe and America. This diminution may be due to "a wider dissemination of education with an increase in sophistication, a less authoritarian social structure, and a decrease in sexual prudery and inhibition." A shift in clinical manifestations of conversion hysteria from gross forms to anxiety has certainly taken place in Europe and America since World War I, but no such reduction in frequency or in the clinical forms of conversion hysteria has been reported in developing countries. Other hysterical features (perhaps related to the reasons given above for the somatization in depressives) are vague aches and pains, functional visceral disorders, and the sensation of burning frequently complained of in primitive societies.

Are There Culture-Bound Syndromes?

There are some mental disorders that in the past have been labeled "culture bound." Further study suggests that these are not really separate syndromes ranking with schizophrenia and hysteria. Although they may be graced with a local name and imbued with a distinctive and perhaps exotic-sounding symbolism rooted in that culture, they are basically the standard

syndromes described in the *American Psychiatric Association Manual.* If some specific instances of a disorder in a non-Western culture are difficult to label within that system, they are no more difficult than some instances of disorder that occur within Western culture. As Hallowell said of the well-known cannibalistic *windigo* symbolism, which is sometimes expressed in the depressions and schizophrenias of the Cree and Ojibwa: "If enough cases of *windigo* were collected, it might become apparent that they fall along a continuum of states comparable to those seen in other cultures, and that only the content of the delusion is specific to the Cree or Ojibwa."

Koro is another example. The fantasy that the penis will withdraw into the abdomen and that the patient will die is sometimes expressed in the schizophrenias or hysterias of south China and Taiwan. Not infrequently, sufferers of this disease clamp the penis in a box to prevent retraction. Some authors have regarded *koro* as exclusive to Southeast Asia. But Baasher reported from the Sudan that several of his patients expressed fears that their penises were shrinking, and, like the Asiatic patients, attributed the damage to excessive masturbation. Similarly a melancholic Jewish American patient complained of "the peculiar feeling that his sexual organs were somewhat foreign to his body and that at times he could not even feel that they were there. This impression was so strong that the patient would frequently grab himself by the sex organs in order to be certain that they were still there." Perhaps the most that can be said is that if fantasies regarding the damaged

penis, its causes, and consequences were collected from around the world, there would be a much greater clustering and intensity of kora-like imagery in Chinese culture. Rin explained its prominence by linking it with the traditional Chinese world view. The world is divided into the *yang* (male, hot, dry, and related to the sun, life, and the right side) and *yin* (female, cold, wet, and symbolized by the earth, death, and the left side of the body) principles. The belief is held that in patients with *koro, yin* predominates over *yang.* The shrinking of the penis is believed to be the result of this predominance, and the cure lies in taking medicines and foods rich in *yang.* The superstition is widespread that a corpse has no penis, which explains the fear of death resulting from its retraction.

A variety of other culture-bound syndromes can be interpreted in a similar way: the magical fear syndrome, *susto,* described in Latin America; the *zar* sickness of North East Africa and Iran; the brain-fag syndrome of some African groups; and the crazy-moth syndrome of the Navaho.

Another group of culture-bound disorders, the *latah* group of imitation reactions, require a different interpretation. This syndrome is usually triggered by a fright (a loud noise, unexpected gesture, even a stimulus word, such as “snake” or “tiger”) which results in some or all of the following behavior: an exaggerated startle reaction, echolalia, echopraxia, coprolalia, copropraxia, and automatic obedience. The episode is usually brief—a few

minutes to an hour or two—and there is usually no alteration of consciousness. The syndrome is commonly regarded as an idiosyncrasy rather than a disease, and the sufferer often provides unwilling entertainment for his associates. It could be argued that this group of imitation syndromes warrants a separate diagnostic category in an international classification. It seems to have much more to do with a type of ego structure more commonly found in primitive peoples than with the kind of cultural symbolism observed in *windigo* or *koro.* Its distinction lies in its structure rather than its content. But once again it is not culture bound.

This syndrome first attracted widespread medical attention when it was reported among French Canadian peasants in Maine and Vermont by Beard in 1880. His report was translated widely in French, Italian, and German journals. The report particularly provoked the interest of Gilles de la Tourette, who probably erroneously linked the syndrome with the syndrome of coprolalia and tics, which still bears his name. Almost immediately, Beard's "jumping Frenchmen" were identified with the highly similar *miryachit* reaction found in Siberia and with the *latah* of Malay. Virtually identical patterns have been described in Japan among the Ainus, and among several cultural groups in Mongolia, South Africa, Burma, Java, and elsewhere.

Generally speaking, the syndrome is common among those of lowly status who are self-effacing and docile in character. Domestic servants are

common among the afflicted. This observation has led to one interpretation of its cause an expression of a conflict between submission and rebellion arising from "an unconscious connection between submission and a dreaded and desired passive sexual experience." Others have seen it as a mocking behavior involving identification with the aggressor or as a primitive anxiety-relieving mechanism still available to children and primitive people, but not to adult Western man. Murphy commented on the frequency of Malayan childhood games with strong elements of suggestion which might offer training for entrance into such hyper-suggestive states as *latah.* This concept receives support from the observations of similar games in rural Quebec and their possible relation to a pattern of startle response.

Finally the famous *amok* reaction should be mentioned. It was first described in Malaya but has since been seen in many other parts of the world. *Amok,* a characteristically male reaction, is usually precipitated by frustrating circumstances, but physical stresses, such as acute infections, sleep deprivation, and intoxications, may act as precipitating or reinforcing factors. Several phases have been described: After an initial withdrawal, there is a period of meditation with loss of contact with the world, persecutory ideas, and a mood of anxiety and rage; this is followed by a stage of automatism, the *amok* proper; suddenly the subject will seize a weapon and attack anyone in his way. He may commit multiple homicides, may mutilate himself, and is frequently killed by frightened neighbors. With recovery of consciousness the

subject may pass into a phase of depression. There is usually amnesia for the *amok* period. Like *latah, amok* can more properly be regarded as a reaction occurring in individuals of primitive ego organization wherever they may be found rather than as a state bound to any particular culture. Reports that in Malaya and Java the incidence of *amok* fell after the authorities jailed *amok* runners indicates that social measures can curb frequency and specific forms of such reaction types.

Frequency of Mental Disorder

Sweeping statements have been made regarding differences in the total frequency of mental disorders between vast geographical and cultural areas, such as Asia and North America. However, nothing definite is known about such gross differences. On a manageable scale, cross-cultural comparisons of total and relative frequency of mental disorders have been made, using hospital records, key informants, and field surveys of selected population samples. Hospital records are obviously ill suited for epidemiological purposes because of the multiple cultural and local factors that determine hospitalization. The key informant technique is valuable in identifying gross disturbances in smaller communities, but less useful in urban settings and for less visible types of disorder. Field surveys are beset with difficulties because of differences in the resistance of the population to interview, language equivalence problems, cultural differences in doctor-patient relationships,

and the lack of comparability of studies by different investigators owing to differences in survey techniques.

Several investigators, however, have succeeded in overcoming at least some of these difficulties and have provided some preliminary findings. The work of Lin and Rin, of Leighton and his group, and particularly of H. B. M. Murphy deserve special mention in this regard.

Between 1946 and 1953, Lin and Rin surveyed three Chinese communities and four aboriginal Malayo-Polynesian groups on the island of Taiwan. The aboriginal groups were at varying levels of social development and acculturation. Using a key informant and home-visit survey technique, they covered some 11,000 Aborigines and 20,000 Chinese.

Their method was such that only the major types of psychiatric disturbances were counted, but the investigators and the method used were the same for the various cultural groups so that there is some degree of comparability of rates of disorder within this survey. The gross findings were that the lifetime prevalence rates of total mental disorders was practically the same among the Aborigines (9.5 per 1,000) as among the Chinese (9.4 per 1,000). The most significant differences were found between one of the aboriginal groups, the Atayal (who were the most primitive and least acculturated but the most poverty stricken), and the Chinese. The Atayal

showed significantly higher total rates of psychoses. Organic and manic-depressive rates were considerably higher among the Atayal but schizophrenic rates were lower than for the Chinese. Rates of alcoholism were much higher *(p* >0.001) among the aboriginal groups compared with the Chinese. The authors explain these differences as owing to differences in rates of acculturation, general health conditions, and genetic factors.

Leighton and his group, which included anthropologists and Western-trained indigenous psychiatrists, compared the mental health of rural Nova Scotians (Canada) with rural and urbanized Yoruba (Nigeria). A standardized interview, field survey of a probability sample of the populations was the major technique, but key informant and hospital data were also utilized. The technique was such that reliable data were obtained only on the minor psychiatric disorders rather than the psychoses. The findings showed fewer differences between the groups than expected. Definite psychiatric disorders were found in 21 percent of the Yoruba villagers, 31 percent of the urbanized Yoruba, and 31 percent of the rural Nova Scotians. Rates of significantly impaired individuals showed more marked contrasts: 15 percent for Yoruba villagers, 19 percent for urbanized Yoruba, and 33 percent for rural Nova Scotians. There was also an unexpected similarity between the groups in symptom patterns.

B. M. Murphy used a key informant technique to determine active

prevalence rates of schizophrenia (whether hospitalized or not) in fourteen Quebec villages of contrasting cultures, including Anglo-Protestant, French Canadian, Irish Catholic, Polish, and German. Significant prevalence differences were found between the communities.

There were also differences in sex distribution, age of onset, duration, pattern of hospitalization, and other characteristics. Murphy explained the differences in cultural terms. For example, he suggested that the very high rates of schizophrenia among women in traditional French Canadian communities may be owing to severe role conflicts. The ideal woman in these communities is one who marries early, has many children, works hard, and is submissive to her husband. About a generation ago, however, higher education became available to women and an independent career beyond the home or convent became a possibility. Study of individual cases showed this role conflict "reflected in the symptomatology of the female schizophrenics attempting to avoid, to escape from, or to destroy the type of marriage which their society sought to tie them to." Similar conflicts, which vary according to culture, were associated with schizophrenia in the other groups. Murphy suggested that the following circumstances in a culture are commonly linked with the precipitation of schizophrenia: a problem of choice that affects the individual deeply; pressure by the community to make a definite choice; contradictions or confusions in the guidance the culture provides; chronicity in the sense that the problem persists until a decision is taken.

Conclusions

In this review, we have briefly considered the history and some of the major findings and theoretical constructs of the field of transcultural psychiatry. Space limitations have not permitted a comprehensive coverage. For example we have omitted the area of comparative healing practices; of attitudes to the mentally ill according to culture, as well as the entire field of mental defect; the patterns of use of altered states of consciousness (psychedelic states, trance states, and mystical states); the relation of rites of passage to mental health; and many other aspects that fall within the legitimate province of transcultural psychiatry.

Questions have been raised as to the value of transcultural studies; some have regarded it as a preoccupation with exotica. We see the field as having both theoretical and practical implications. As with other branches of science, the comparative method provides a powerful aid to understanding and conceptualizing. Transcultural psychiatric studies help to distinguish the essential and universal from the peripheral and parochial. These studies are indispensable in arriving at conclusions about the basic factors shaping personality, the core characteristics of psychiatric disorders, and the essentials of preventive and therapeutic activities.

But there are also practical applications. Insights gleaned from transcultural studies are vital for equipping mental health workers who cross

cultural boundaries. These include psychiatrists from developing countries who come to the Western world for training; mental health workers located in multiethnic settings; and social workers, physicians, nurses, and perhaps even economists and engineers who are involved in foreign aid programs. The field is in its infancy, valid insights are difficult to achieve and call for laborious interdisciplinary alliances, yet transcultural psychiatric studies would seem to have a definite place in our attempts to come to terms with our conflict-laden, rapidly shrinking, global village.

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