

American Handbook of Psychiatry

**CROSS-CULTURAL STUDIES
OF MENTAL DISORDER**

George A. DeVos

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An Anthropological Perspective

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e-Book 2015 International Psychotherapy Institute

From *American Handbook of Psychiatry: Volume 2* edited by Silvano Arieti, Gerald Caplan

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CROSS-CULTURAL STUDIES OF MENTAL DISORDER

An Anthropological Perspective

Areas of Cross-Cultural Work Related to the Concept of Mental Illness

One of the central tasks of comparative studies in transcultural psychiatry is to examine the various manifestations of so-called mental ill health in various cultures and the provisions therein for dealing with them. The cross-cultural investigation of mental health, therefore, raises a number of questions that have been dealt with only imperfectly by the studies done to date in cross-cultural work.

faulty physiology or socialization that tend to produce similar distress systems definable as mental illness, irrespective of culture? Are these cross-culturally identified forms of mental or emotional disturbance generally recognized as such by the members of the culture?

1. Are the syndromes generally recognizable by the psychiatric profession of an invariant nature? What is essential or universal, and what is culturally specific in diagnosis of symptoms?
2. Are there any truly culturally specific forms of mental and emotional aberration?

3. How do different cultures define and treat mental illness? What is the relative efficacy of the respective forms of treatment? How does cultural expectation
4. color or determine the behavior of the mentally ill?
5. Are there true differential incidences of internal maladjustment or social maladaptation related to cultural differences?
6. There are questions related to comparative epidemiological differences and mental disorder, problems in the modern age derived from the rapidity of social change and mobility between groups of various culture backgrounds. What are the effects of geographic and social mobility or acculturation or change of cultures on mental health and emotional well-being?
7. We have not completely resolved issues concerning the relationship of various less psychiatrically defined forms of social deviancy to mental health. How, for example, do such phenomena as the use of drugs, forms of crimes or delinquency, situations leading to murder and suicide vary within specific cultures? To what extent are they due to environmental situations and to what extent do they result from structural personality variables leading to selective vulnerability?

The limited scope of this chapter does not permit exhaustive reporting of pertinent literature. What can be done, however, is to illustrate these topics by example and cite some sources for more detailed reading in the subjects

considered.

Cross-Cultural Recognizability of Psychiatric Problems

There has been considerable controversy about whether severe mental illness is recognizable cross-culturally and whether, for example, individuals who are schizophrenic in Western culture are classified as “crazy” in most cultures. This issue is compounded with the fact that there does indeed seem to be some culturally specific role-playing behavior expected of individuals with severe mental pathology. The structural defect, therefore, may be disguised or distorted perceptually in terms of patterned behavior induced in given cultures. For example, Weinstein and Schulerbrandt, on the basis of research in the French Antilles, concluded that delusions function not as an escape from reality but, to the contrary, as a faulty adaptive attempt at maintaining feelings of reality and identity. Thus, to the degree that such an attempt is made, the delusional symbol chosen will be related to the cultures’ preferred channels of social relatedness.

In some cultures, the psychotic is expected to be dangerous and excitable. One may suppose that with such an expectation there will be a higher incidence of aggressive behavior in one culture as compared with another, induced by defensive aggressiveness in dealing with an emotionally or mentally aberrant individual. It is my own subjective impression that

hospitalized Japanese psychotics observed in the early 1950s, at a time prior to the introduction of tranquilizing drugs, were less aggressive compared with American psychotics. Fewer restraints were used in Japan as compared with the United States. The care and nurturing extended by attendants was more intensive compared to custodial treatment afforded by United States hospitals. Similarly, Benedict and Jacks' and also Marinko reported less aggressive behavior for African schizophrenia.

To date, the anthropological evidence points up great divergencies in the labeling process of deviant behavior, including psychosis. Even in such contiguous areas as the highlands of New Guinea, one finds contrasting reports of the recognizability of what would be to us obvious psychosis. In Edgerton's empirical work in the four East African tribes he examined, he found the general capacity to give fairly accurate descriptions of behavior said to characterize a psychotic person. These definitions of psychotic behavior were widely known even by those who had never witnessed them. In effect, there was a known pattern of expectations of psychotic behavior in which individuals could be readily placed. The less severe the mental or emotional problems, the more varied the pattern of recognition cross-culturally and the more varied the explanations for them. Edgerton, in his conclusions after a general examination of the literature related to this problem, suggested that the recognition of mental illness cross-culturally is a social process that involves moral and jurial considerations. Considering an

individual as a mental problem in every society studied involves placing the individual in a status that carries with it some alteration of rights and responsibilities. It follows from this that the recognition process for most cultures is not primarily a problem of a medical diagnosis. As he pointed out, defining someone as “crazy” takes the form of a social negotiation involving not only the person afflicted but in some instances his family and lineage. This is so without denying the real disturbances in thought, affect, and conduct that require some form of psychiatric management, however it is defined. In given cultures, the diagnosis of mental illness has the effect of lowering the marriageability of members of a given family. Therefore, the definition of aberrant behavior is more likely to be put in supernatural terms that do not carry the stigma of hereditary taints rather than being put in medical diagnostic terms, which, for this culture, imply a family lineage with defective genes. It goes without saying that for many cultures including Western culture into the nineteenth century, the concept of possession by an outside force is one of the most generally held explanations for psychotic behavior.

Cross-Cultural Comparisons of the Essential Constituents of Psychiatric Diagnosis

A related problem to the recognizability of psychiatric symptoms cross-culturally is the question whether manifest symptoms of a given broad clinical diagnosis such as depression or one or another of the designated

behaviors considered collectively under the rubric of schizophrenia are indeed invariant syndromes. It may well be that some characteristics considered essential relate more to the cultural setting than to the structure of the given disturbance itself. Murphy, Wittkower, and Chance made a comparative study of the syndrome of depression. They examined reports submitted by sixty psychiatrists from thirty different Western and non-Western cultures. They found certain elements almost invariably associated with what is diagnosed as depression. However, some symptoms usually considered to be related to depression in Western Christian cultures, namely, thought retardation, guilt, and self-depreciation, prove to be absent in some other settings. Murphy suggested that the essential psychiatric essence of depression does take on particular local cultural features. Differences can even occur within Western settings. Note, for example, variation in the nature of depression reported by Grinker for Midwestern United States and Hamilton for England.

Similarly, Murphy, Wittkower, Fried, and Ellenberger stressed the pervasive presence of social and emotional withdrawal, flatness of affect, auditory hallucinations, and general delusions suggesting that the essential diagnosis of schizophrenia involves some general libidinal withdrawal of a very severe and regressive nature and a concomitant rupturing of the ego's capacity to differentiate internal processes from external stimuli. But manifestations that are considered symptomatic of schizophrenia are also

markedly different, depending on the culture. For example, Wittkower and Rin found that so-called catatonic rigidity, negativism, and stereotypical behavior are reported more commonly in India than in the other countries surveyed. Bazzoui and Al-Issa found that schizophrenia patients in Iraq and Italy appear to show more expressive and aggressive traits than such patients in the United States.

Such surveys today indicate universality in the structural defects in psychological organization, even though final definitive word as to the exact nature of schizophrenic withdrawal is not yet in. Cross-cultural examination, however, is helpful in moving toward the solution of this still puzzling psychiatric problem.

Are There Culturally Unique Psychiatric Symptoms?

The psychiatric use of anthropological material started at a time when members of the Western European cultural tradition had an implicit faith in the fact that they were the end product of an evolutionary sequence. The maturational potentials of Western man were considered superior to those of members of more primitive cultures. Hence, compared with Europeans, members of so-called primitive cultures were expected to exhibit biologically more primitive evolutionary capacities as far as mental functioning was concerned. It was presumed, therefore, that one could successfully find

normative examples of thought in primitives that survived only as aberrations or as forms of psychopathology among modern humans.

More recently, among the anthropologists there is an assumption that culturally unique patterns are to be found in mental illness since medical diagnoses of Western psychiatry are totally culture bound. Therefore, one would expect that socialization elsewhere would produce unique patterns related to unique features in psychosexual developmental experience. Those starting from either the premise of racial inferiority or of cultural relativity have therefore scrutinized the anthropological literature to find examples of aberrations uniquely limited to particular non-Western cultures.

A totally different point of view starts from assumptions emphasizing the universality of the psychic apparatus and the universality of given developmental sequences in psychosexual development. From this point of view, seemingly unique forms of mental aberration are merely interpreted as variations in the cultural content of overt behavior, rather than as the manifestations of truly unique differences in underlying maladjustive psychological structures.

Of those in transcultural psychiatry attending to what has been termed culture-bound reactive syndromes, P. M. Yap has done the most systematic and detailed examination of the literature.

Among the most noteworthy of the culture-specific forms appearing in the anthropological literature is the phenomenon known as *amok*. *Amok*, as it appears in the Malayan and Philippine groups, has been well described by Beaglehole. It starts with a characteristic depression. The depression deepens, and the person withdraws, going into some type of disassociated trance-like condition wherein his energies are mobilized. He then rushes into some form of violent attack. It is reported that others cannot restrain him, and he very usually is put to death as a final resort. These happenings are reported over and over in surveys of culturally peculiar behavior, yet the actual evidence of reported incidence of such behavior is limited to two or three authors. A graduate student, James Russell, who spent two years in Southeast Asia, carefully reviewed the published reports and reported incidence of *amok* and concluded that almost no actual reports of killing individuals who go berserk are to be found in recent years. Also, publications on *amok* are a spiral of secondary references based on very little eyewitness material. It may well be that *amok* occurs but rarely, perhaps no more frequently than similar behaviors in distraught individuals in other cultures, yet in the Malayan culture area there is a mythology about *amok* that may make it seem to be a more frequent occurrence than it actually is.

More recently there have appeared descriptions of a related type of berserk behavior called "wildman behavior," occurring in the New Guinea highlands. Newman was able to give us some indication of the cultural and

personal stresses occurring prior to its outbreak. It seems to have instrumental as well as expressive purposes. From an expressive standpoint, the individuals who become afflicted are usually under some kind of internalized strain to achieve a status of which they are incapable. They also have need to act out certain aggressive urges or unconscious attitudes. Instrumentally, by manifesting wild-man behavior one alters status in such a way that the social expectations change. One gains the distinct impression from Newman's description and interpretations that it is a kind of disassociated phenomenon permitting affective display similar to what one finds in various forms of spirit possession such as what occurs in voodoo.

Usually possession phenomena, such as in voodoo or in trance, are not defined as pathological but simply as a part of religious ceremony and expected social behavior without any connotation of deviancy attached. The comportment of individuals under possession is culturally expected and sanctioned. In other cultures, possession is culturally defined as pathological and hence an illness. This is true for such behavior as *latah*, described by Van Loon, and *imu*, described for the Ainu of Hokkaido by Wielawski and Winiarz. In these disturbances, one finds such symptoms as echopraxia and echolalia, where the afflicted person, usually a woman, helplessly imitates what another person says or does. The onset is often caused by some traumatic fright related to fear of spiders, snakes, or even the names of such animals. Individuals in this state very often use obscene words or frank sexual

gestures. Aberle saw *latah* as a dissociated state that, from the standpoint of its social functions, is produced in individuals who have disturbance of ambivalence with respect to submissive behavior. Submission symbolically implies passive sexual experience related symbolically to being attacked. The individual fears being overwhelmed but at the same time is sexually attracted. Almost invariably, it occurs in individuals of submerged or subservient social position. This type of behavior is found in Japan, related to what is described as “fox possession” in many rural areas, or sometimes possession by other animals such as dogs.

Though the content is different, Lee described the type of dissociative behavior occurring among the Bantu of South Africa. Women suffer a type of malady called *ufufuyana*. They have nightmares about the *tokoloche*, who is described usually as a bearded dwarf with a large phallus who assaults women at night. There are pains in the lower abdomen, sometimes with accompanying paralysis, and seizures with the appearance of incoherent talk seemingly in a strange language. Ambivalence about sexual interest is very obvious from the stated symptoms. Another related illness reported in literature is that of so-called Arctic hysteria or *pibloktoq*. There is loss of consciousness, the individual is amnesic after the occurrence, behavior is uninhibited, the individual tears off his clothes, he wanders off, some are reported to eat feces. Also the individual seems capable of feats of strength beyond his ordinary capacities. In all these reports one has to distinguish

between the social functions and the cultural definitions of dissociated behavior. First, as Newman indicated, there are functional resolutions of personal impasses in what is culturally perceived as aberrant behavior. The same resolutions may occur in another culture by means of possession states that are considered normal within the culture. The social functions, or cultural definitions as well as the specific cultural content of behavior, whether it be *amok*, wildman behavior, *latah*, or possession and trance, must not be used to forego psychiatric or psychological considerations of the actual similarity in the use of mental mechanisms related to dissociation that may well be common to all these seemingly disparate activities. Nevertheless, the social psychiatrist must become aware of cultural patterns to the extent of understanding how particular internal stress is derivative of given cultural expectations.

Other illnesses of a non-dissociative nature are sporadically reported. There are, for example, what might be called malignant anxiety situations in the *susto* reported in the Andean highlands. One finds symptoms of depression and anxiety following severe fright or shock. Interpretation given is that somehow there has been a loss of the soul. Such malignant anxiety often is found in places where there is a strong belief in malevolent witchcraft. Such belief is reported widespread in the anthropological literature of Africa, for example. The most severe form of this belief in sorcery is that of the Australian aborigines where deaths have been reported of

individuals who have learned that sorcery has been worked on them. Specific to Chinese culture is the appearance of extreme forms of fear related to the delusion that the penis is shrinking and may disappear into the body. This state, known as *koro*, flared up most recently in Singapore after a rumor of radioactive fish spread through the Chinese community there.

Yap attempted to classify these various forms under a general syndrome of reactive psychoses, psychogenic reaction. Various forms of disordered consciousness have subcategories, primary fear reactions, morbid rage reactions, culture-specific phobia. The various forms of possession states are considered dissociated reactions. Yap's terminology "reactive psychosis" has much to recommend it, but might be misleading if we think of psychosis as related only to disruptions of early ego formation. Two features stand out in these various diseases despite some of the similarities in content. (1) There are dissociated states in which the person is in an altered state of consciousness. The person is out of his mind literally but in a manner that suggests the repressive mechanism of hysteria rather than the breakdown of ego boundaries characteristic for more severe forms of energy withdrawal found in schizophrenia. The terminology "hysterical psychosis" is, along with Freud's original use of the term "psychosis," used to indicate a condition whereby the ego is overwhelmed by instinctual forces. However, the chief mechanism of defense is repression rather than severe forms of projection or introjection with partial rupturing of ego boundaries as found in what is

usually classified as psychosis and schizophrenia. (2) Some cultural forms are related to extreme states of panic or anxiety owing to given belief within the culture, either that the person has been condemned to death by sorcery or that he has lost his soul or that his penis will shrink inside his body. These beliefs are specific to given cultures, but an afflicted individual who defines himself as having become a victim of a given condition feels a degree of panic leading to physiological as well as mental disorganization. The relationship of the former cases to possession is evident because in each instance ego dissociation occurs. The person is literally not himself when in the afflicted state or in the trance state. This is equally true for the rage situation of *amok* or wildman behavior or the hysterical response reaction to the use of a forbidden or anxiety-provoking term, which sends the individual into the dissociated state.

As will be discussed briefly in the conclusions, one can distinguish between social adaptation and internal adjustment in viewing any given human behavior. On the one hand, one can see some seeming aberrant behavior or expressed experience functionally related to social adaptation in some instances. For example, trance dissociation can be seen as non-pathological and, in effect, a socially desirable state in some instances. In other instances, uncontrolled behavior cannot be adaptively harnessed to social purpose in such a way as to give it a positive meaning, but is defined by the group itself as maladaptive and pathological. Seen on the other hand from

an internal adjustment standpoint of psychiatry, the fact that the individual characteristically uses mechanisms such as repression gives some underlying unity to these various behavioral maneuvers whether they are in the context of socially sanctioned possession behavior or are called into play by individuals of low status who are in need of some excuse of the expression of pent-up feelings related to sex or aggression. Similarly, mechanisms of repression can be used to ward off ungovernable anxieties produced by a cultural belief.

The Epidemiology of Mental Disorder

Surveys attest to the differential appearance of mental disorders cross-culturally. The best approach to why these differences appear is to assess the various ways that culture can influence mental health. Leighton and Hughes produced one of the best all-around compendiums of the impact of culture on mental disorder. They used, as a basis for their concept of culture, Hallowell's idea of shared psychological realities of patterns and emotions to describe what it is they mean by culture when they are talking about culture as causative of mental disorder. They discussed a large number of culture-specific disorders, already mentioned. They then discussed a series of propositions about the effect of culture on mental health.

1. Culture may pattern disorders.

2. Culture may produce personality types especially vulnerable to certain kinds of disorders.
3. Some cultures may be thought to produce a higher incidence of given psychiatric disorders through certain child-rearing practices.
4. Cultures may be thought to effect psychiatric disorders through types of sanctions and strictures on acceptable behavior.
5. Culture may perpetuate malfunctioning by rewarding it in certain prestigious roles. (They quote Devereux and Kroeber and Kluckhohn⁸⁸ here.)
6. Culture may be thought to produce psychiatric disorders differentially in given segments of the population through certain stressful roles. (They quote Linton here.)
7. Culture may be thought to produce psychiatric disorders through the indoctrination of its members with a particular kind of sentiment. (They quote Leighton.)
8. Complexity of culture may, per se, be thought to produce psychiatric disorders, as voiced by Sigmund Freud in *Civilization and Its Discontents*.
9. Culture affects breeding patterns selectively. (Laubscher discussed Bantu cross-cousin marriage and the incidence of schizophrenia.)
10. Culture, through patterns of faulty hygiene, can produce toxic and

nutritive deficiencies influencing mental functioning.

Culture Change and Mental Health

One may illustrate questions of stress related to change and acculturation by examining some recent specific research on the influence of urbanization cross-culturally.

Abstract conceptualizations in regard to the stress of migration need to be tested in concrete detail in given settings, in given cultures, ranging from ancient civilizations to small isolated, so-called primitive groups who in previous ages were relatively cut off from external contact. Social psychiatry can interest itself in the human response to change, the patterns of adjustment and adaptation that occur given the various forms the stimulus of change takes. A specific issue subsumed under macro issues involved in the effects of industrialization generally is the question: Does urbanization per se cause stress on immigrants to a city?

There is already in American sociological and psychological literature considerable reference to the assumed psychological stress occurring during migration into the city on the part of rural populations. In the United States, recent large-scale epidemiological studies have produced conflicting results. For example, Malzberg and Lee, doing a study of the difference between New-York-born black and white populations in New York compared with rural or

foreign-born populations found a much higher incidence of mental illness in recently arrived foreign or minority group immigrants compared with those of similar origin growing up within the city. Ødegaard, on the contrary, in doing an extensive study of mental illness for the whole of Norway, has found a higher incidence of mental illness in Norwegians who do not move into the city. What does anthropological research reveal is the case in different societies where urbanization within given cultures can be separated out from acculturation compounded by urban migration? I shall quote from a series of papers appearing in a recent symposium dealing with this subject as well as others examining responses to change. Alex Inkeles did a direct examination of the fate of personal adjustment in six different cultures. He cited empirical material that suggests that rather than leading to problems of stress, urbanization seems to be correlated with better mental health as measured by the medical-psychiatric indices used in his research. Increased education, rather than leading to less social cohesiveness as has been claimed by some, has a fairly consistent significant positive effect on adjustment as far as test measurements of psychosomatic symptoms indicate. Even exposure to mass media seems to operate integratively rather than causing internal disruption of any sort.

Employment and such occupations as factory worker, according to Inkeles's results, are not conducive to psychosomatic complaints in any of the cultures sampled.

Inkeles summarized his cross-cultural report by saying that whatever may cause psychosomatic symptoms in young men in developing countries, it is something other than exposure to modernizing institutions, such as school, factory, city life, and mass media. The act of migration itself within his sample is not related to the greater symptomatic appearance of problems. One of the principal difficulties with theories of urban transition as stressful is not due so much to an incorrect view of city life as to a mistaken and romanticized image of what village, rural, or tribal life is typically like. Inkeles opposed the view that the daily life of traditional villages in most cultures was inherently healthier than almost anything village residents might encounter in urban industrial settings. There is too ready an idealization of the economic security enjoyed, or the cooperation and affiliative nature of village interaction and the availability of emotional support in times of personal need or crisis. Any objective evaluation of the internal structures of village life in any of a number of cultures would attest to the relative infrequency of such idealized situations.

Similarly, Ernestine Friedl, on the basis of intensive research in Greece, found that much of the suppositions about stress in the city are due to a priori assumptions about theoretical polarities placing the village and the city in opposition to each other. In summarizing the literature, she indicated such ideal typical constructions are a Procrustean bed and hence poorly suited as conceptual tools for dealing with real situations. The polarized traits

supposedly operative are invalid because they simply do not appear in an actual living context, such as rural and urban Greece. Such classification is too vague and imprecise to be used for comparative empirical studies. In sum, Friedl raised serious questions as to the acceptability for actual anthropological research of the often cited folk-urban, Gemeinschaft-Gesellschaft, particularistic-universalistic, and traditional-modern dichotomies. Friedl's research method demonstrates a more observational anthropological approach, in contrast to the survey approach taken in six cultures by Inkeles. Nevertheless the conclusions are similar.

Edward Bruner, studying modernization of the Batak of Sumatra, made a cogent critique of some of the assumptions in the psychiatric literature about the relationship of rapid social change to stress. Bruner's interpretation of the anthropological data forwarded both by psychiatrists and anthropologists found evidence both of examples of internal conflict being produced by rapid change and other situations where no such manifestation of symptomatology of stress is reported. A central issue, therefore, is to separate out the variables, differentiating out those situations of change that induce conflict from those situations that do not.

Any further resolution to the questions raised depends on intensive investigation rather than simple correlational analysis. One possibility in resolving differences of results would be to attempt some generalization to

the effect that rates of mental disorder may be a function of how successful the host culture is in providing ways of handling the stress aroused. The research problem, then, according to Bruner, would be one of investigating intensively the culturally provided solutions to stress. Mental illness simply becomes one alternative response to an attempted resolution of aroused stress. Second, the concept of stress itself must be examined in cultural context through the actual perceptions of the individuals involved rather than on an a priori basis derived from a Western perspective.

Bruner offered his case study of the Batak of Sumatra as an illustration of a quite successful resolution of the possible stresses inherent in modernization. In Bruner's explanation of why the Batak have adapted themselves with facility, he indicated that it is a flexibility in role making rather than simply role taking. The Batak headmen who regulate the *adat*, or law, do not perceive the outsider's categories of traditional and modern, for example. Seen through the subjective experience of the Batak themselves, one finds that a Batak headman is flexibly adapting his behavior to changing situations and that the actors in his culture are in this sense, creative agents interpreting the changing world in which they live and testing their interpretations by the feedback they gain from their behavior. If there is flexibility and adaptability in the agents, because of such capacities in their adjustive mechanisms, then adaptation to modernization may go on with considerable facility and a minimal experience of stress.

What Bruner pointed out for the Batak is a sense of implicit confidence in their law. Their family and kinship networks remain intact and their belief system is modified without any sense of disruption. On the basis of Rorschach and thematic apperception test protocols gathered from both urban and rural Batak, Bruner found no evidence of differences related to their urban adaptation and internal adjustment. This contrasts heavily with Bruner's previous experience among American Indians, where renunciation of Indian identity seems to be necessary in order to take on change. Bruner pointed out that there is a choice necessary in the case of American Indians and American Negroes. There is an inherent opposition between being Indian and being white. A person has to make a choice; he cannot be both at the same time. But a Batak, in contrast, does not have to renounce his own social group or personal identity in order to urbanize because there is no felt opposition between being Batak and becoming a modern Indonesian.

Bruner was well aware that he was challenging some of the favorite tenets of Western sociologists, including that of Marx, which regard, as Bruner put it, "Religion or ideology as the frosting on the cake of economic reality and political power." For Bruner, it is precisely the belief that the *adat*, the *nomia* of the group, is unchanged that allows for such successful relative modernization and urbanization without anomie on the part of the Toba-Batak of Sumatra.

Takao Sofue examined some of the new stresses faced by those left behind in village life as rapid urbanization continues in Japan. With the considerable population movement into the industrial economy of modern Japan, those left in agriculture are facing serious readjustments, both internally and socially necessitated by a progressively devitalized rural life style. There are a number of dilemmas occurring specific to particular rural positions within the primary family.

In sum, three basic points are touched on in these studies.

1. Urbanization does not of itself imply disruptive modernization.
2. There is difference in the psychocultural effects of urbanization in situations where those moving to the city move into cities that are part of their own culture as opposed to situations of immigration into a different culture.
3. Mental health in migratory situations is undoubtedly related to the degree of discrimination or receptivity of the migrant within the new setting. The American migratory pattern differs greatly from other migratory situations and cannot be used to generalize about the stress nature of migration and its adverse effects on mental health.

H. B. Murphy suggested that mental illness and physical illness are not clearly correlated with mobility, since in some places immigrants have lower hospitalization rates, but do seem to be related to the size and coherence of

the immigrant group. He suggested that the degree to which the immigrant is encouraged to individuate himself may help and hinder him, its penalties being higher hospitalization rates.

Marc Fried suggested that forced relocations, in urban areas, for example, disrupt working-class communities and that this disruption results in very real grief. The way that people adjust to this disruption is in a sense the way they adjust to forced mobility, “the higher the status the larger the proportion who have been able to cope successfully with the social changes implicit in relocation.” Thus, in a sense, people who were already making it best in the terms of the mobile society are those people who have the highest amount of status to fall back on. These people adjust best to the changed situation.

Various other studies, including some epidemiological surveys, indicated that the number of social maladaptations (as well as what seem to be overt manifestations of internal maladjustment) is differentially related to ethnic group membership as well as to patterns of social and geographical mobility. Some forms of stress seem to be related to cultural change as well as to minority status. Particular cultural patterns tend to induce types of manifest breakdown in individuals, given situations of change, in spite of the fact that evidence could not be found that these tendencies toward social maladaptation are in any way related to particular stresses during the early

formative periods in socialization. Such problems are not limited to situations of extreme change, such as those occurring when there is contact between nonliterate and technologically advanced cultures. They may occur with migratory shifts of people from rural to urban settings.

For example, in a Rorschach study of acculturated and non-acculturated Algerian Arabs, Miner and DeVos reported increased signs of intrapsychic stress in the content symbolism of a sample living in a minority status position in the city of Algiers prior to the Algerian revolution. An increase in anatomical and sadomasochistic content was also evident in records of Chinese-Americans reported by Abel and Hsu and in Goldfarb's sample of American Negroes. DeVos discussed the implications of these findings (true also for Japanese-Americans) for some concept of chronic stress in situations of minority status.

Abrahams discussed the effect of the matrifocal family structure among American blacks. The matrifocal family structure had its roots in slavery and is reinforced by the present difficulty of black males in finding work. Such economic difficulties tend to lead to frequent acts of desertion by the father and to consequent continued reinforcement of woman-dominated family patterns, with growing boys facing psychological problems concerning male identity.

Ethnopsychiatric Healing Practices

It has been noted that in curing aberrant mental states ethnopsychiatric techniques are often at least as successful as, if not more successful than, Western ones. Hughes gave a fairly general cross-cultural survey of healing practices, both physical and mental, and pointed out that the problems presented by public health, including mental health, within particular cultures are intimately related to the functioning of the social system.

The techniques used in therapy in various cultures seem to bear some relation to child-rearing practices. Kiev and Whiting and Child noted that magical medical beliefs are more often accepted for their compatibility with personality variables than for their actual physiological utility. A variety of authors have discussed the importance of faith in primitive psychotherapy and the many similarities between the techniques of primitive societies and those of modern societies. Hallowell discussed the wide range of mental illness treated by Apache shamans; A. H. and D. C. Leighton, the Navaho use of cultural values to help integrate the ill back into the world of the well; and Devereux, detailed and incisive studies on the Mohave.

The volume edited by Ari Kiev, *Magic, Faith and Healing*, brought together a number of thoughtful papers covering the fact that therapy of functional disorders is most efficacious with the symbolic representations and beliefs of the individuals treated. All psychiatry of functional disorders,

including modern Western psychiatry, is therefore to some degree at least folk psychiatry. Of particular interest in this volume is La Barre's article on the therapeutic effect of confession as a social therapy in given American Indian tribes. It is, in effect, both internally adjustive and socially adaptive to the individual, reintegrating him into the society. Jane Murphy cited the psychotherapeutic aspects of shamanism in Eskimos. Prince gave a cogent description of the nature of indigenous Yoruba psychiatry in Nigeria. Bert Kaplan and Dale Johnson related peculiar native Navaho symptoms to their social adaptive and maladaptive meaning. They reported that the most prevalent form of Navaho psychopathology is what is termed "crazy violence" or "crazy drunken violence." The Navaho simply have no specific term but call it going crazy or being drunk. It is seen more often as a natural consequence of drunkenness rather than something that would be classified as mental illness, and as such is often dismissed as typical Indian drunkenness. These symptoms are so regular and recurrent among the Navaho that there can be little doubt that it has special significance. The individual, however, seems to use drinking in order to get into an altered state of consciousness wherein he can express behavior that otherwise would be unconscionable to him. Some of this so-called drunken behavior results in the murdering of family members and suicide on the part of the individual. When he is going crazy he does not care what he is doing; he goes wild. Kaplan and Johnson pointed out that this behavior differs somewhat from the usual hysterical situation in that

the person knows he is acting crazy but does not care and aligns himself, in effect, with his worst side. In hysteria, on the other hand, the victim refuses to acknowledge his illness as his own, attributing his behavior to whatever has invaded him. In the crazy violence of the Navaho there is seemingly a heroic element of being willing to take the consequences of one's behavior. The individual avoids no pain, suffering, or trouble but has a reckless willingness to die and to be hurt. Psychodynamic interpretation would see this as a direct discharge into action of warded off instinctual impulses and inner tensions absent of ego control. The point is ultimately, when one reads the description of the psychopathology by Kaplan and Johnson, that it is not unique to the Navaho but is simply culturally institutionalized and a relatively frequent occurrence. This is the issue, not that we are discovering some unique mechanisms that work for the Navaho and are not to be found elsewhere.

The effectiveness of Navaho curing ceremonies appears to be based on two points. There is the elaborate procedure of purification itself, which convinces the patient and the community that the bad stuff is vanquished and can no longer cause trouble. The second point is that the concern and goodwill of the group is focused on the individual in the sense that he receives the "good vibrations" of his group and receives a moral boost that makes him motivated to feel better inside. In other words, the individual, the total mobilization of the community, and the procedure itself have a powerful force on the individual, suggesting to him that he can be and in effect is being cured.

Relationship of Socially Deviant Behavior to the Concept of Mental Health

Despite the increasing availability of cross-cultural evidence, there are a number of issues on the borderline of what are legitimately considered psychiatric problems, such as crises of adolescence, forms and patterns of sexual deviation, delinquency and crime, suicide, and social problems as related to the use of drugs.

For example, the forms taken by crime or delinquency in cultures or situations leading to murder and suicide are variously defined in different cultures, but from a social psychiatric standpoint may have common etiological features. There are highly divergent viewpoints among social scientists as to how much the appearance of such phenomena is owing to environmental induction and problems of adaptation versus how much to structural personality variables leading to a selective vulnerability toward deviant behavior in given individuals.

American, and more recently, European societies are perhaps unique in the degree to which various forms of deviant behavior are identified as indicative of internal maladjustments rather than maladaptations. In a survey of the uses of psychological tests and writings of psychologists concerning delinquency compared with sociologists, one gains a general impression that psychologists are more prone to deal with middle-class samples of the population and sociologists are more apt to deal with lower-class youth.

Questions of social maladaptation are more prepotent as determinants operative in lower-class youth, although maladjustive defenses are also apparent in some cases. In contrast, middle-class delinquents show more evidence of possessing neurotic maladjustments about aggression than do lower-class youth.

There is no question that the social adaptations of homosexuals differ from society to society. For example, Japanese and American cultural attitudes are highly divergent. A systematic cross-cultural study of similarity or differences in underlying adjustment patterns in homosexuals awaits to be done.

Chafetz noted that, cross-culturally, drinking and alcoholism are not the same. Alcoholism is a function of the cultural attitude toward the use of alcohol and the degree of social stress to which the drinker is subject. The use of alcohol by Indians (introduced by white contact throughout the Americas) has, almost from the beginning, been described by white observers as culturally and individually destructive both in North and South America. In such countries as Mexico and Peru, drinking continues to be recognized as a major social problem. For example, Simmons noted that drinking and drunkenness were, in the Peruvian village he studied, virtually universal. The suppression of aggression remains a key problem in this culture, and alcohol serves to reduce much of the anxiety and strain by releasing aggressive as

well as friendly feelings in normally shy and inhibited persons.

Hallowell, Helm, DeVos, and Carterette, and Coult placed more emphasis on the release of aggression than on the release of friendliness. These anthropologists, among others analyzing the adjustive and adaptive use made of alcohol among Indians, pointed out that it fulfills a release function in respect to aggression for many Indian groups who are over-controlled in daily face-to-face relationships.

Conclusions: The Distinction between Inner Adjustment and Cultural or Social Adaptation

The various issues and problems related to an understanding of the interpretation of culture and mental disorder discussed above are far from being resolved. It is the major contention of this chapter that a clear self-conscious distinction between adaptation and adjustment would help greatly in orienting further research. Moreover, the anthropologist and the sociologist, both theoretically and methodologically, must give greater respect to the realities of inner adjustment patterns as continuing integrative structures of personality and, as such, as being highly determinant of motivated human behavior. Given such respect, there should result more adequate contributions from anthropology and sociology to answering questions of issues to transcultural or social psychiatry.

For the most part, in the literature of psychology as well as anthropology and sociology, the concepts of adjustment and adaptation are loosely used in a roughly equivalent manner. They indiscriminately refer both to the internal structures we subsume under the concept of personality and, in many instances, to mutually adaptive processes of human communication and interaction that occur in social role relationships. More generally, they are used indiscriminately as concepts referring to man's response to his environment. Converse concepts, maladjustment and maladaptation, can refer to some deficiency or structural lack in a capacity for response in an individual or simply to some form of response itself that is inadequate to the purposes or survival of the individual. The term "adjustment," as used in this chapter, is not culturally and situationally relative; it assumes an ideal progression of maturation that is potential for all human beings, but the realization of which may be culturally fostered or deformed. It is often said today that to be well adjusted in a bad environment itself could be pathological. This is not the proper use of the term "adjustment" in the psychodynamic sense intended here. Indeed a person can be deformed maturationally by his culture in such a way that he adapts well to situations of human brutality. One cannot assume, therefore, that he is internally well adjusted in the psychodynamic sense. While it is possible for an internally well-adjusted person to survive in a bad environment, one presumes, however, that he will attempt to effect external changes in the environment,

whereas a person who is maladjusted will not be so well equipped to bring about desired ameliorative change. To put it the other way is to define adjustment only in terms of adaptation rather than maturational potential. It is most helpful, therefore, to theoretically maintain a clear distinction between internal structuring of personality related to the concept of adjustment and social behavioral responses that can be seen as adaptive or maladaptive for the individual within his culture.

This distinction has been elaborately elucidated by Clyde Kluckhohn in his publication on Navaho witchcraft. Kluckhohn, in a detailed study of the social and psychological functions of witchcraft beliefs and practices, kept this essential distinction. Adaptation, for him, was defined as the relationships of individuals within society. For example, witchcraft was functionally adaptive in deflecting aggressive feelings out of the group onto more distant outsiders. Internally, for the individual, Kluckhohn considered witchcraft beliefs to be adjustive in that they acted as an outlet for affective states that otherwise would be disruptive to psychological functioning. Witchcraft functions could be seen in some other contexts as relatively maladaptive to the social group, or as evidence of relative maladjustment in one person compared with another who had less need to have recourse to witchcraft but could handle his relationships more directly. In this latter sense, adjustive functions are to be viewed in the context of personality organization or personality structure.

The relationship between adaptation and adjustment can be, indeed, complex, whether examining behavior of one individual from two points of view or similar behavior of different individuals in different contexts. Theodore Schwartz has introduced the innovative concept of pathomimetic behavior to explain the seeming appearance of maladjustive behavior as part of religious ceremony in some cultures. There can be socially adaptive forms of behavior that, for purposes of strengthening religious belief for the individual as well as in the group, mimic, either consciously or unconsciously, forms of behavior that usually are indicative of maladjustment of organic pathology. For example, a shaman may indicate behaviorally that he is possessed by a deity by exhibiting seizure phenomena of a type observed to occur in epileptics. In native medicine, epileptic seizure, a frightening form of behavior to behold, is usually explained as the intrusion of an alien force, often a deity, into the body. To indicate that he is possessed, therefore, the person manifests a seizure. In the case of the epileptic, the behavior is maladjustive in the personality structure sense. In the shaman, whatever his state of consciousness or self-hypnosis, the behavior becomes socially adaptive as symbolic of religious ecstasy. In pathomimetic phenomena, the possessed individual has somehow learned to manifest convulsions as a sign that a spirit has entered his body so that communication becomes possible with the supernatural. His manifest behavior may therefore simply be adaptive rather than maladjustive either in structure or function.

If we relate these distinctions between adaptation and adjustment directly to the field of psychiatry, one notes that the traditional problems in psychiatry have been to distinguish between structure and function in respect to organic adjustment problems versus functional adjustment problems. In social psychiatry, or transcultural psychiatry, however, a new dichotomy appears. The distinction must now be made as to whether or not relatively debilitating or painful personal adjustments or maladjustments are socially adaptive or not within a given cultural context.

Psychiatrists and psychologists, when viewing mental health, are usually concerned specifically with psychological adjustive mechanisms viewed within Western culture, and to this extent they can without care slip into ethnocentric value judgments that govern the diagnosis and treatment of what they perceive to be psychiatric illness. Anthropologists in turn are focused on patterns of social adaptation, that is, whether the individual remains, or how he remains, or how he was brought into, or excluded from, social participation. Caudill suggested that comprehension of the working relationship between anthropology and psychology requires today, for the psychiatrist as well as others, some understanding of the concept of culture as a key concept, just as it is necessary for anthropologists to better understand personality structure or personality functioning as keys to motivated human behavior. He suggested that we avoid tendencies to reductionism in either group in studying the interrelationship of these systems.

For modern psychiatry, operating both within Western culture and outside, there is the disturbing consideration that knowledge of the causes of malfunctioning by itself may not help in the treatment of problem behavior—unless there is a sharing of beliefs and symbol systems between therapist and patient concerning the efficacy of treatment—to the degree that a malfunctioning is not based on an organic problem. To that degree, treatment is irreducibly symbolic, in the literal sense of the word. What has already been apparent to some social or transcultural psychiatrists in extending or reinterpreting the causes of mental health or illness is the necessity to clarify or differentiate between those concepts or definitions of behavior prevailing within a given culture and those concepts being imposed externally on the meaning of behavior from a Western psychiatric framework. If no attention is paid to indigenous perceptions of mental illness or to the meaning of its particular forms within a culture, there can be no therapeutic process. Western trained psychologists or psychiatrists, using only traditional descriptive psychiatry or psychoanalytic formulations, can easily alienate themselves from symbolic communication with members of the culture in which they are functioning.

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