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EXOTIC PSYCHIATRIC SYNDROMES

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Somatic pathology is universal and so is psychopathology, and what is more, psychopathology appears in basically identical clinical forms, wherever it occurs in the world. According to Forster:

> Psychiatric syndromes or reactions, by and large, are similar in all races throughout the world. The mental reactions seen in our African patients can be diagnosed according to Western textbook standards. The basic illness and reaction types are the same. Environmental, constitutional, and tribal cultural background merely modify the symptom constellation. Basically, the disorders of thinking, feeling, willing, and knowing are the same.

And Edgerton writes:

> It is remarkable how alike the African conceptions of psychosis are to the Western-European psychoses. The Africans of the four tribes do not regard a single behavior as psychotic which could not be so regarded in the West. That is, they do not produce symptoms which are understandable as psychotic only within the context of their own cultures. What is psychotic for them would be psychotic for us.

This uniformity of psychopathology is puzzling, particularly for those of us who have accepted Homey's and other "cultural psychiatrists' " theory of the pathogenetic role of the environment. How could as different a culture as that of a Stone-Age Arauca produce the same clinical picture as that of a

highly industrialized society? In somatic medicine, we accept, as a matter of course, that a trauma produces a fracture in an Arauca, as well as in an astronaut. What does differ, may be the cause of the trauma: The Arauca may fall from a tree, the astronaut may have a flying accident. The repertoire of psychological responses is as biologically limited as that of somatic responses. Fear, anger, sadness, joy, and anxiety resulting from inner conflicts are universal. The cause of the conflicts may differ; but transgression of a taboo creates anxiety in the same way as transgression of one of our society's standards.

Furthermore, the most incisive psychological influence occurs in early childhood. Stone-age parents may be affectionate or hostile, accepting or rejecting of their children, as are our parents. Technological advancement is no guarantee of healthy emotional parent-child relationships. Kubie expresses this idea in the following manner:

> We must consider the interactions of developmental *universals* and of cultural *variables* of those ingredients of the neurotic process which are unique for human kind. . . . The neurotic potential is universal in all human beings, partly inherent in the biological character of development and partly in the universal relationship of infancy.

The uniformity of psychopathology is not absolute. Deviations occur in the following areas: morbidity (psychiatric epidemiology);[1] relative frequency of the various diagnostic categories; existence of a group of

psychiatric syndromes which are limited both geographically as well as in their occurrence in only few population groups. The morbidity varies greatly even within racially, ecologically, and economically similar populations. For example, the Iatmul and the Arapesh are two tribes who live near each other in New Guinea. The morbidity among the Iatmul is considerably higher than among the Arapesh. There is a high incidence of severe mental disorders among the Ojibwas and Aiviliks, as high as in any technologically advanced society. It is, therefore, not true that psychopathology increases with the increase of complexity of a society. The relative frequency of different diagnostic categories varies not only among different nations or societies, but changes may occur in the same population group. Manic states appear definitely more often in African cyclothymic patients than in ours; affective disorders are more frequent in Italy than in the USA. However, manic-depressive psychoses are observed less often in Italy now than only a decade ago. Suicidal rates differ widely in different countries and/or different

population groups of the same country. Finally, another deviation from the global universality and uniformity of psychopathology is represented by a group of psychiatric syndromes, which Arieti and I called “exotic psychiatric syndromes” in the first edition of this Handbook. Yap used the term, “culture-bound reactive syndromes,” Weidman and Sussex, “culture-bound responses to culturally patterned stresses,” Enoch et al. simply, “some unknown psychiatric syndromes.” This group of syndromes has in common only—aside

from their geographical and cultural limitations—that they are not observed in the West and that they have a bizarre, psychosis-like flavor, though most of them are to be classified as neuroses. They present fascinating clinical pictures, but even more importantly, they offer to the student of cross-cultural psychiatry a rich source of investigation. Sapir exhorts us:

> Perhaps it is not too much to expect that a number of gifted psychiatrists may take up the serious study of exotic and primitive cultures in order to learn to understand more fully than we can out of the resources of our own culture the development of ideas and symbols and their relevance for the problem of personality.

Before I go on to describe the various syndromes, I want to caution Western-trained psychiatrists about some diagnostic pitfalls.

1. Most of us have abandoned the definition of psychiatry as the science of abnormal behavior as too limited. However, psychiatric diagnosis is still based to a great extent on the observation of deviant behavior. But what is normal for us, may be abnormal in other cultures, and vice versa. Here are some examples. In the West, suicide is considered a sign of emotional disorder. In Japan, it is expected behavior under certain circumstances.' No sane woman on the island of Dobu (Melanesia) would have left her cooking pots unguarded for fear of being poisoned.' We would suspect paranoia. Eskimo mothers used to accept, as a matter of course, the killers of their sons in their son's stead. Homosexual practices between uncles and nephews are

expected and normal behavior among some Papuan tribes. In Tibet, a father's second wife is inherited by his sons, when he gets old. Arapesh males may marry simultaneously a mother and her daughter. A Navajo may marry a widow; later on, he discards her and marries her daughter. The Urubus of the Brazilian jungle feel fully dressed with a string around their penises as their only garment; they feel naked and terribly embarrassed when they lose the string. Chinese and East Indian males may attribute their discomfort to semen having gone up to their brains.

In the West, hallucinations are considered almost pathognomonic for the diagnosis of psychosis. In non-Western countries hallucinations are a normal requirement for priests and shamans during their religious or healing rituals. In fact, priests and shamans are often chosen for their ability to hallucinate and to fall into states of altered consciousness. These hallucinations differ, however, from those of psychotics, since they begin and end with the religious ceremonies, since the visions and voices are usually benign, not threatening, and since they require, to be induced, monotonous repetitive sounds or continuous rhythmic movements.

To illustrate the difficulty of differential diagnosis in a culture in which hallucinations and religious beliefs, similar to delusions, are normal, I cite the occasion when A. H. Leighton asked T. A. Baasher of the Clinic for Nervous Diseases in Khartoum, Sudan, how he would distinguish religious beliefs from

delusions. Baasher told him of a Sudanese member of a religious sect who began hearing voices, telling him to kill his leader's rival. He went from village to village to find the rival whom he did not know personally. After a long search, his voices told him that *there* was his man. In spite of the man's protestations that he was no religious leader, the hallucinating Sudanese speared him. According to Baasher, it was in keeping with the Sudanese culture and considered normal to hallucinate and even to kill on one's master's behalf. But the composite of all the elements in this case made no sense even from the particular culture's point of view. So, Baasher diagnosed the murderer as a case of paranoid schizophrenia. In other words, the diagnosis of mental disease in primitive societies cannot be made by observing behavior that is abnormal according to our standards; even behavior patterns that are normal in the culture in which they occur are no proof of mental health. We must apply the same criteria that we use in our patients with due regard for cultural peculiarities.

2. Another diagnostic pitfall, particularly in tropical and semitropical countries, is the simulation of functional psychiatric disorders by infectious diseases. It must be kept in mind that positive laboratory findings are not decisive in populations in which these infections are endemic. The most important conditions to rule out are:

a) Malaria, particularly the pernicious type caused by the Plasmodium Falciparum, can produce psychiatric symptoms, such as

confusional states with excitement or stupor, an amok-like syndrome, epileptiform attacks. According to Carothers, malaria accounts for 3.4 percent of first admissions to mental hospitals in Kenya.

b) Trypanosomiasis (sleeping sickness) was according to Tooth the "commonest cause of mental derangement throughout large areas of West Africa." Whereas malaria has been eradicated in many parts of the world, sleeping sickness is still a scourge of many parts of Africa.

The first symptom is usually a change of habits; the patient becomes increasingly irritable, then apathetic and morose; the speech is slow and tremulous; sleep disturbances occur in 60-70 percent of the cases. Delusions, hallucinations, and manic attacks are not rare. According to Tooth, every type of schizophrenia may be simulated. The end stage consists of a euphoric dementia, punctuated by episodes of irrational and impulsive behavior.

c) Ankylostomiasis (hookworm disease) may appear at first as a depression, sometimes of a severe degree, until the profound anemia and the positive laboratory findings together with the reversal of the psychological symptoms, when the patient is treated for hookworms, confirm the diagnosis.

d) Massive infestation with Ascaris lumbricoides in children. I have observed several cases in Ecuador with initial symptoms of confusion, epileptiform attacks, carpopedal spasms in children between four and six years of age. In two of the

children, the confusion disappeared dramatically after the patients vomited clumps of the parasites.

e) Syphilis is very common in many underdeveloped populations, although a positive Wassermann cannot be taken as a sure indication of the disease. Yaws is frequent in tropical countries and can be responsible for the positive serology.

General paresis, once believed to be rare among non-Western people, occurs usually without the complete deterioration and dementia seen in the West. Carothers has seen a fair number of cases in Kenya. The most prominent symptom was that of manic excitement.

3. Nutritional deficiencies are common among underdeveloped populations and may simulate or be accompanied by psychiatric disorders. The deficiencies which produce psychological symptoms most frequently are pellagra and kwashiokor.

Pellagra may be difficult to diagnose, in spite of the classical triad: dermatitis, diarrhea, and dementia. The dermatitis may be absent or hard to recognize in colored people; diarrhea is frequent in hot climates for causes other than pellagra; dementia is an end stage. Initially, the patient shows sudden irrational mood changes; or he may be constantly irritable, has paranoid delusions, and may even hallucinate.

Kwashiokor is a disease caused by protein deficiency. It is unknown in

populations whose food contains certain amino acids, either through animal proteins (meat, fish, or milk) or through vegetal proteins (beans). Infants develop normally at first, that is as long as they are nursed. After weaning, they lose their previous liveliness, become apathetic, morose, growth is retarded, skin lesions appear, and the children succumb often to an intervening infection.

4. A fourth class of diagnostic difficulties for Western psychiatrists are drug-induced psychiatric symptoms. The use of certain mushrooms or leaves in order to produce psychological effects is very widespread. They are taken during religious ceremonies or, sometimes, to increase endurance for particularly strenuous tasks. Most of these drugs alter the state of consciousness. Their effect lasts usually only a few hours, but at times it persists and, as in some of our patients on LSD, a latent psychosis may become apparent.

The psychologically most destructive drug, aside from opium and its derivatives, is alcohol, a Western import to most primitive people. During my years among the Indians in Ecuador, I saw violent crimes committed almost exclusively under the influence of alcohol.

Not all primitive people use drugs. It seems that they are used mostly by peoples who live under particularly harsh natural or man-made conditions in

an attempt to escape into an illusory paradise.

The healing practices of primitive populations, long neglected, have recently attracted considerable interest. In the West, we pride ourselves in our rationality. We strive to recognize the etiology and pathogenesis of an illness. We expect to discover the underlying unresolved conflicts and to help our patients to take responsibility for their thoughts, feelings, and behavior. We hope that our patients will thereby feel less helpless and inadequate and be able to cope with the vicissitudes of their lives. The native healer starts out from the same premise. He, too, tries to understand the cause of his patient's illness which he may attribute to the transgression of a taboo, in an affront to a deity or spirit, in the malevolence of supernatural forces, or in the witchcraft of a sorcerer. The etiological agents are assumed to produce their pathogenetic effect by either introjecting evil objects into the patient's body or by depriving him of his soul, sexual powers, normal intelligence, etc. Native healers have keenly observed what re-establishes happiness to a child who has fallen from the good graces of his mother. He runs to her, hides his face in her lap, and therefore submits to her mercy. This show of submission may be enough to win back mother's acceptance. Sometimes, mother must prove her power by punishing the child, before she can forgive him. But then atonement, the acceptance of the punishment, frees the child of all guilt feelings. These observations of basic human behavior are applied as treatment methods. The shaman finds out where and when his patient has

been “bad.” He then makes the patient admit and helps the patient to a cathartic confession. The offended powers may be mollified by this act of submission alone or the shaman, as mediator of the deity or spirit, subjects the patient to punishment in form of physical, psychological, or economical pain.

Another healing method, also derived from the observation of basic human needs, is the Shaman’s permission, as representative of the group, for the patient to let go of his repressed feelings. For example, the native healer may allow a male patient, whose culture demands complete denial of dependency needs, to indulge in these otherwise unacceptable feelings or he will encourage a female patient to vent her hostility, if her group’s standards expect self-effacement for women.

In other words, native therapy is not as senseless as it has arrogantly been claimed in the West, but it is an often effective way to help patients by furthering self and group acceptance. Native technique usually involves the mobilization of intense emotions. The shaman has an advantage over us, since his patients have usually absolute faith in his healing powers. I believe that the shaman’s trances and hallucinations are one way to demonstrate his powers and also a way to show to his patients that it is possible to get out of these states.

Latah

Latah is a syndrome, first described in Malaya, but recognized later on in many parts of the world. The etymology of the word "latah" is not known. It may derive from the Malayan words for love-making, tickling, or creeping. In Malaya, this syndrome has been known for many centuries and is regarded more as an eccentricity than a disease. It occurs mostly in middle-aged or elderly women. In other parts of the world, it is equally as frequent in men. Sometimes, it has assumed epidemic proportions.

Similar syndromes have been described in Siberia under the names of "myriachit" and "tara;" among the Ainu of Hokkaido, Northern Japan, as "inu"; in Siam as "bahtschi"; in Burma as "yuan"; in the Philippines as "mali-mali"; in Madagascar as "ramenajana"; in Nyasaland as "misala"; and as "banga" in Zaire. It has also been reported from Somaliland, the southern part of the Sahara, and from Tierra del Fuego without any particular name. Some authors believe that Gilles de la Tourette's disease and the syndrome called by Beard "Jumping Frenchmen of Maine" belong to the same psychiatric category.

Clinical Picture

The patients in Malaya are usually middle-aged or elderly women of dull intelligence and of compliant character in low socioeconomic positions. They become increasingly fearful and seclusive. The disorder may start with a

sudden fright. Among the Ainu, the illness begins when the patient has seen or imagines having seen, or stepped on, a snake. At first, the patient repeats the words or sentences of other people, especially of persons in authority. Then, the patient imitates, in pantomime fashion, the gestures and acts of other people or does the exact opposite of what other people do or expect her to do. Later, the patient starts to mumble incomprehensible sounds which, still later, become clearly curses or obscenities, words hitherto alien to the patient. The echolalia, echopraxia, and coprolalia appear to be uncontrollable by the patient who, as soon as she has pronounced the curse words, gives signs of feeling utterly embarrassed and frightened. Latah patients are often subjected to ridicule. Adults and children may tease them unmercifully until they beg their tormentors to leave them in peace or until, less often, they become violent.

In other parts of the world, latah patients may present additional symptoms. In Africa, they may run into the forests; in Tierra del Fuego, they may climb dangerous cliffs without regard to their safety. During these fugues, the patients, who are most often males, become violent and present a picture similar to “running amok.”

The “Jumping Frenchmen of Maine” belong to a sect—The United Society of Believers in the Second Appearing of Christ—which came to the United States from Wales in the eighteenth century and settled along the

eastern coast. During their rites and at the height of their religious ecstasy, one member starts to jump, roll around on the ground, and utter barking sounds. The others follow suit. Most of them stop this behavior at the end of the religious ceremony. A few, however, remain in this state or begin to jump and shake again if a sharp command is directed at them, or even if someone just points a finger at them.

I don't believe that the "Jumping Frenchmen of Maine" should be included in the latah syndrome. One essential feature of latah, coprolalia, is absent, which in psychodynamic terms is as important as the echolalia and echopraxia, as we shall see. Gilles de la Tourette's disease (also called *Tic de Guinon, maladie des tics impulsifs, myospasia impulsiva,* multiple tics with coprolalia, or *imbacco)* begins in children between the ages of five and fifteen years with spasms of the orbicularis oculi. Later, it spreads to other muscles of the face, then neck, upper extremities, and at times, to the muscles of the whole body. At the same time or somewhat after the appearance of the tics, all the symptoms of the latah syndrome are added. The course of the disease is unpredictable. It may become progressively worse, ending in a severe obsessive-compulsive neurosis or even in a psychosis. In other cases, the symptomatology remains stationary or the disease may run a paroxysmal course, the paroxysms lasting for weeks or months.

One of my patients showed first symptoms at the age of eight years.

Coprolalia appeared several years later and was particularly hard to understand in this very gentle, compliant boy. At twelve, he developed a frank psychosis. He stopped hallucinating at twenty-one and has remained severely obsessive-compulsive ever since. The patient is now forty-three years old. Sometimes, signs of his old disease break through. He starts to stutter, repeats his last words and those of the persons whom he talks with, and finally lets go of a barrage of obscenities which are very much out of keeping with his usual vocabulary.

Pibloktok, also spelled Pibloktoq, or called Pibloktoq hysteria, or the "copying mania," or amurakh, are the names of latah-like syndromes, occurring among Polar Eskimos. These are paroxysmic states of excitement, some lasting just a few minutes, others for hours. The patients disrobe themselves or tear off their clothes, run away, roll in the snow, jump into the icy waters of a lake, or try other unusual acts, and grimace. Glossolalia (mimicking animal sounds or pronouncing meaningless neologisms) and coprophagia are common.

In *amurakh,* or "copying mania," which occurs in Siberian women, the mimicking of other people's words or acts is the main symptom.

Menerik is a syndrome which has been observed in Eskimos of both sexes. It manifests itself in paroxysms of wild screaming and dancing and may

culminate in epileptiform seizures.

Interpretation

The latah patient is a compliant, self-effacing person who, before becoming ill, has tried to blot out all aggressiveness, so as not to feel the conflict between her compliance and aggression. The latah symptoms appear when these attempts at repression fail. Her hostility breaks through and shows in her curses and obscenities. She still tries desperately to check this breakthrough by obliterating her spontaneity—saying and doing only what others have said or done before her. I consider the appearance of coprolalia as an essential symptom of latah and would therefore not include the "Jumping Frenchmen of Maine" syndrome.

This interpretation, obviously, does not tell us why latah patients choose their particular symptoms and not those presented by our patients with similar psychodynamics. Mimicking and the expression of obscene words must have a meaning in the cultures in which latah occurs, which they do not have in other cultures, and only a very intimate knowledge of cultural peculiarities and idiosyncrasies will allow a full understanding of the symptom choices. I have often marveled about the frequency with which psychotic episodes in Latin-Americans begin with a homosexual panic, until I understood that the word *maricón* (homosexual) is the most derogatory term,

used constantly in Spanish-America. Contempt and self-contempt has no parallel or equally meaningful word in Spanish.

Amok

Amok or running amok is another syndrome first described in Malaya, but also found in many other parts of the world, for example in the Philippines, in Africa, in the Caribbean, in Tierra del Fuego, etc. The "going berserk" of the old Vikings was probably similar to running amok. It used to be common in Malaya until the beginning of this century. According to van Wilfften Palthe, it was observed with regularity among the patients of the old Batavia Hospital until the old building was replaced by a modern structure and until modern medical care was instituted in 1914. Since then, amok has become rare among the hospital's patients. Van Wilfften Palthe claims that he has never observed or heard about a case of amok among the many Malayans living in European countries.

In the early days of American occupation of the Philippines, a number of American soldiers became victims of amok Moros, a Moslem tribe. When the Moros' level of education was raised, amok disappeared. Maguigad claims that amok is still quite frequent in the Philippines. It also appears to be fairly common among the Papuans of New Guinea under the name of "Negi-negi" or "Lulu," and in Melanesia.

The “Puerto Rican Syndrome,” or *Mai de Pelea* is, in my opinion, similar to amok, although the outcome is usually less gruesome. As in amok, the patient withdraws at first and gets into a brooding mood. All of a sudden and without any recognizable provocation, he becomes violent and strikes out at anyone near him.

According to Zaguirre and Kline, the premorbid personality is impulsive, emotionally hyper-reactive, according to other authors schizoid. However, the psychodynamic interpretation is probably the same. The patient’s attempt at conflict-solution by repressing his hostility is failing. He makes a last desperate attempt by withdrawing within himself. According to Maguigad, amok derives from the Malayan word “amoq,” which means engaging furiously in battle. It is a life or death battle against a feeling of complete disintegration. I have sometimes sensed this feeling in a patient who from a catatonic stupor suddenly switched to catatonic excitement. It is a last-ditch attempt at survival against the inner forces which are about to disintegrate him.

The Bantus express this idea in their belief that a person destined to die may escape death by killing someone else in his stead.

In other words, the amok patient externalizes his desperate need to destroy the death-bringing inner conflict by killing other persons. The most

violent cases of amok seem to occur in cultures which demand repression of hostility, as in Malaya, Bandung, and the Philippines. In Puerto Rico, violence is more acceptable, and, in fact, expected of males under certain circumstances. The investment of energy in the repression of hostility is not large and therefore the violence—once repression fails—is of a lesser degree.

The multiple violent acts occasionally committed in Western countries by persons with a schizoid personality resemble the clinical picture of running amok and may be due to similar psychodynamic mechanisms. These acts have been the subject of several novels by authors like Camus and D'Annunzio. The differential diagnosis between the violent acts of paranoid or catatonic schizophrenics and of amok patients is helped both by the history—since amok patients did not show any delusions or hallucinations—and by the lack of amnesia in schizophrenic patients.

Pseudo-amok is a syndrome in which the patients seem to simulate all the symptoms present in amok, except that they do not hurt anybody and that they give themselves up meekly once cornered—a situation which does not occur in real amok. Pseudo-amok is probably a hysterical syndrome.

Koro[2]

The origin of the word "koro" is not clear. It may stem from the Malayan

word “kuru,” shake; the Javanese word “keruk,” shrink; or according to Yap, from the Javanese word for tortoise. The Chinese and Southeast Asians call the glans penis tortoise.

The Chinese name for the syndrome is “shook yong.” It has been known in China for centuries. One of their emperors died supposedly of shook yong. The Chinese author Pao described it in 1834. He claimed that it is precipitated by exposure to cold or by the ingestion of cold or raw food. It starts out with abdominal pain, spasms, and cyanosis of the limbs, retraction of the penis and scrotum into the abdomen; then, there is trismus, and finally death. It is a serious emergency. According to Chinese folk medicine, it is related to the middle female meridian which is supposedly governed by the liver—the organ most susceptible to worry, fear, and anger. One of the triggering causes is believed to be excessive intercourse or improper sexual relations.

The symptoms usually start without warning. The patient, usually between thirty and forty years of age, is suddenly worried that his penis will disappear into his abdomen and that he will die. To prevent this from happening, the patient has to grip his penis firmly; when he becomes tired, his wife, relatives, or friends help him. The Chinese constructed a special wooden clasp for this purpose. At times, fellatio, practiced immediately by the patient’s wife, can stop the phobia, otherwise it can last for days, or even weeks. Linton describes a female equivalent of koro in Borneo where the

patient is afraid that her breasts are shrinking as well as her labia, which would lead to the disappearance of important female characteristics.

The Chinese believe that shook yong is caused by an imbalance of yin and yan. The prevalence of the female factor yin must be counteracted by the administration of a drug which increases yan, for example, powdered rhinoceros horn.

Our male patients, afflicted by castration anxiety, choose different symbols to express their fears. They may be worried about the length of their penises, of being homosexual, etc. What makes Southeast Asian or Chinese patients adopt their particular symbolism is impossible to say without intimate knowledge of their cultures. However, a recent outbreak of a koro epidemic might give us some hints.

For about ten years prior to 1967, rumors circulated that males who ate chickens injected with hormone pellets developed large breasts and became impotent. In July 1967, an outbreak of swine fever in Singapore was stopped through vaccination. The injection of the vaccine was equated with the injection of hormones with the disastrous effects mentioned above, in those who had eaten inoculated pork. It is possible that a few people of the poorer class who could afford to buy only chicken necks (the hormone pellets are injected in the necks) developed gynecomastia and that this change in

secondary sexual character signified decreased masculinity.

Susto and Espanto

"Susto" and "espanto" are two Spanish words which can be translated as fright or fear, but in this context refer to names used throughout Central and South America for psychiatric syndromes. They are used for a number of clinical pictures which have in common only that they occur most frequently in small children, and are characterized by an intense fear or anxiety. Somatic pathology is also rather common.

The affected child becomes tearful, easily frightened, loathes to be left alone, loses his appetite or acquires strange appetites, and is irritable. This clinical picture may have started after a fall, after encountering a snake or other frightening animals or situations, or for no apparent reason. In some countries, the terms "susto" and "espanto" are used interchangeably, and in others "espanto" is reserved for the more severe cases.

The popular explanation holds the loss of soul responsible for the syndrome. The soul flees and seeks shelter in caves or trees, particularly at night, at which point the child wakes up frightened and crying and cannot be consoled.

It is up to the shaman to identify the reason for the soul's flight. It may

be because of a parent's neglect or the malevolence of spirits or a witch. I believe that in every case of susto in children which I have seen in Ecuador, an organic cause was present, either malnutrition or infectious diseases or parasitoses. These somatic ailments often made the parents irritable with their children and this led to the children's fears and anxiety. In the few cases of susto in adults, we may recognize diagnoses from anxiety neurosis to acute schizophrenic panic.

Whitico Psychosis

This syndrome has been observed among the Eskimos who live in the Hudson Bay area, particularly among the Cree Eskimos. The Ojibwas of Southeastern Ontario call this syndrome "windigo."

Clinical Picture

The first symptoms may be anorexia, nausea, vomiting, and diarrhea. The patient falls into a brooding mood, fearing that he has been bewitched, that he will become a "whitico." A whitico is a supernatural figure, a giant skeleton, made of ice, which devours human beings. The patient withdraws more and more, is sleepless, refuses to eat, and sinks into deeper and deeper melancholia. The frightened family calls on a good shaman to counteract the witch's or bad shaman's spell. Most often, the patient improves after

appropriate magic is applied. But, at times, particularly in remote areas where no "good" shaman is available, the patient may coldly kill one or more members of his family and eat them. Cannibalism has been a recognized extreme means of survival among the Eskimos. The occurrence of cannibalism in their phobias or delusions is, therefore, not surprising.

The whitico patient, who acts out his fears, mistakenly believes that the life-saving effect of cannibalism during a realistic emergency (extreme famine), will save him from suffering in an emotional emergency, too. Another motive of the whitico patient may be the use of a folklore tale to realize his sadistic desires. Finally, the stark, cruel Arctic environment must create a feeling of utter isolation in its inhabitants who must crave for the relief of their loneliness, and what could offer greater closeness than the incorporation of another human being?

Voodoo Death (Thanatomania)

Voodoo death has been observed among most primitive peoples. The patient dies without any discernible organic cause when he becomes aware of having transgressed a taboo or when he fears having been bewitched. The following is a typical case report. A sorcerer in New Guinea had been offended by a young Papuan. In revenge, he told the young, healthy man that a few days ago he had put a *bofiet* (an object poisoned by witchcraft) into the young

man's path. The young Papuan appeared immediately extremely ill; he did not talk and seemed completely removed from his environment. Within two days he was dead. The sorcerer was indicted by a Dutch court which, recognizing the bewitchment as cause of death, condemned the sorcerer—who, by the way, admitted his guilt freely—to several years' imprisonment.

Our language is aware of the possible connection between extreme fear and death; we say "frightened to death." But we in the West would expect death to occur only in very rare cases of the most extreme fright, and not for apparently trifling reasons, as happened in the case mentioned above. We ought not to forget, however, that the transgression of a taboo or the feeling of being bewitched is no less trifling for primitive peoples as those symbols which have become charged with explosive meaning in our culture.

In the Bible (II: Sam. 6:6-8), it is reported that Uzzah accidentally touched the ark of God while it was shaken by the oxen which were carrying it. Touching of the ark was strictly forbidden and Uzzah is reported to have died immediately, because of the "anger of the Lord." This account is hardly reconcilable with other statements in the Bible where great care is taken to differentiate voluntary from involuntary crimes (Numbers, Ch. 35; Joshua, Ch. 20). The interpretation that Uzzah died a voodoo death is more likely, since to him the touching of the ark must have meant the transgression of one of the most stringent taboos.

In the West, dying from the fear of, or the expectancy of, death, may not be rare. Arieti has heard from reliable witnesses the case of an elderly man, of the village of Pomerance, Italy who used to say that he would die only when the several-centuries-old tower of the village fell, meaning that he would live for a long time. During a storm, the tower was hit by lightning and did fall. Shortly after hearing the news, the old man died.

Experienced surgeons and anesthetists know that some very frightened patients die during or shortly after an operation for no discernible organic reason. The usual explanation is that the patient went into shock. At the autopsy, only signs of vasomotor paralysis are found, the same as in voodoo deaths.

Actually, voodoo death is only one of the many ways in which emotions act on the organism. We still do not know whether death occurs because Selye's reaction to stress fails or because it involves the vital vascular systems.

Final Remarks

In the preceding pages, I have pointed to a paradoxical dichotomy: On the one hand, there is by now a consensus that mental disorders exist in very much the same form everywhere in the world. No group of human beings is known in which every member can cope with life without the need for

neurotic or psychotic defenses. On the other hand, I described a number of psychiatric syndromes which occur only in a few societies and which are not observed in the West.

Two facts account mainly for the universality of psychopathology: (1) The repertoire of psychological responses to psychological stresses is biologically limited. (2) The parent-child relationship is universal; it does not change with technological advances.

Psychological responses to psychological stresses—anxiety, anger, sadness, etc.—call forth in all human races defense constructs against the disintegrating forces of conflict, for example, externalizations, repressions, phobias—in other words, neuroses and psychoses.

But differences in psychiatric pathology exist; they are:

1. Quantitative, epidemiological differences;

2. Variations of the proportions of the various psychiatric entities: More obsessive-compulsiveness in some groups, more phobias in others, more or less depressions or manic states, more or less schizophrenic reactions, etc.

3. Variations in content: Our patients' delusions talk of radar waves, whereas a Papuan may be afraid to end up in his neighbor's cooking pot. It is hardly surprising that castration fear is externalized to the shrinkage of secondary sexual

> characteristics in a member of a culture in which little boys are constantly threatened to have their penises cut, even for minor infractions; or that mimicking is resorted to as a defense mechanism in cultures which demand that a social inferior agree to every word and deed of his superior.

Is culture also responsible for the quantitative epidemiological differences and the relative variations of the various psychiatric entities among different groups?

Lesbianism was unknown among the Maoris in Australia until new restrictive sexual mores were introduced by missionaries. A previously conflict-free psychological area then became laden with anxiety; when the former sexual freedom ended, a new sexual outlet was found. Sexual psychopathology is rare in societies which do not surround sex with threatening taboos. (For example, among the Trobrianders, and most tribes in East Africa.)

On the other hand, in cultures which regulate their members' daily life by strict rules, obsessive-compulsive neuroses seem to be infrequent, as if the need for this particular defense mechanism had been satisfied by the compulsiveness of the culture, whereas it is more common in societies which allow greater freedom of choice. This raises the interesting question whether our pursuit of ever greater freedom does not exact the tremendous price of more psychopathology.

Arieti, in a paper about the relative frequency of affective disorders and schizophrenic reactions, found a remarkable decrease of the former, which he attributes to cultural changes.

Some authors claim that cultural changes lead always to greater psychopathology. I believe this to be true only when these changes bring about new conflicts (for example, the Maoris mentioned above), when old value systems are destroyed without replacing them with new ones, when a previous group cohesion disappears, when old preferred positions within the group have to be given up (for example, the loss of status of the males among the Yemeni Jews in Israel). However, when the cultural changes help to alleviate old stressful conditions (e.g., the prohibition of cannibalism by Western powers in New Guinea and some South Sea Islands), psychiatric morbidity diminishes.

So far, we have explored whether culture increases the incidence of psychopathology. Can it encourage mental health?

I mentioned already the favorable changes wrought by the abolition of cannibalism, but there is a more basic influence, postulated by some authors, like Roheim and Bertalanffy. Roheim spent several years among the Papuans of Eastern New Guinea. He came to the conclusion that culture is *the* main defensive institution created by man against the onslaught of anxiety.

Bertalanffy calls culture a "psychohygienic" factor; by providing standards of behavior, particularly of interpersonal relationships, it helps to diminish conflict-promoting situations which otherwise would tear apart the fabric of any human group.

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Notes

1 Psychiatric statistics are notoriously unreliable. In addition to the usual difficulties of diagnostic criteria and of communication, mental illness is considered in some cultures to be shameful to the patient, his family, and even to his tribe, and is therefore kept hidden. In other cultures, there may be a remarkable tolerance for deviant behavior, so that patients are not reported unless they become grossly unmanageable.

2 The psychiatric syndrome “koro” must not be mistaken for the familiar central nervous disorder, also called “koro” or “kuru,” which has been observed in a very limited area of the eastern highlands of New Guinea. The disease begins with tremors, which spread all over the body and become progressively worse, muscle incoordination, dysarthria. Death follows within three months to one year. At autopsy, a severe cerebellar degeneration is found. This disease occurs almost exclusively in children and women. Intense investigation in the late 1950s led to the discovery that the disease is caused by a slow-acting virus which is transmitted when the children and women eat the livers of killed members of neighboring tribes. The virus concentrates in the liver. The male adults eat other parts of the body which contain much less virus and therefore are less massively infected. This discovery led the editor of the Journal of the American Medical Association to write an editorial on “On Not Eating Your Neighbor.”