

INTERPRETATION OF SCHIZOPHRENIA

Transcultural Studies of Schizophrenia

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Transcultural Studies of Schizophrenia

I

Introductory Remarks

Transcultural psychiatry studies whatever pertains to the field of psychiatry in relation to cultural differences. The variable in these studies is the culture. Do different cultures determine variations in the incidence, symptomatology, and course of mental conditions? If they do, why and how have they such effects? Is the uniformity of a given psychiatric syndrome or the diversity in various cultures the prominent feature? The majority of these studies take a given geographical area as the object of their research. Other studies have also given importance to time rather than geographical space because even in the same country, culture varies in different historical periods.

With particular reference to schizophrenia, we can study cultural aspects in four different ways. First, we can examine the question of whether the prevalence or incidence of the disorder changes in various cultural environments. We have already discussed this topic in

the previous chapter.

Second, we can attempt to determine whether the culture facilitates, engenders, or hinders the occurrence of schizophrenia. The culture may have such effects in the following ways: (1) by its impact on the internal organization of the family, or by assigning specific roles and emotional values to its members and, more specifically, by establishing special methods of raising children; (2) by its impact on the building of the self-image and its ways of offering compensations for the injury to the self-image; (3) by offering various adverse or beneficial psychological influences on the individual (such as leisure, overwork, competitive spirit, automatization, impersonality, and so forth), so that his psychic resistance may decrease or increase.

The reader can easily visualize how difficult it is to determine the hygienic or pathogenic value of the factors mentioned in the second item in the preceding list. Some of these factors are the same social factors discussed in Chapter 31. Some others have been studied not in reference to schizophrenia but to the human psyche in general in *The Will To Be Human* (Arieti, 1972). We must keep in mind that these social factors generally exist in clusters, cannot be isolated, and

therefore cannot be studied in their individual effect.

The relation between special ways of bringing up children and the vulnerability to schizophrenia has not yet been studied in a scientific manner. The incidence of schizophrenia, however, has been studied in relation to some specific cultures. Eaton and Weil (1955a, *b*) have made interesting studies of the Hutterite community. The Hutterites are a group of people of German ancestry who have settled in the Dakotas, Montana, and the prairie provinces of Canada. In a population of 8,542 people, Eaton and Weil found only nine persons who sometime in their lives had been suffering from schizophrenia and thirty-nine who had been suffering from manic-depressive psychosis. In other words, among the Hutterites, manic-depressive psychosis was 4.33 times more frequent than schizophrenia, whereas in the general population of the United States the rate of schizophrenia by far exceeded that of manic-depressive psychosis. The life of the Hutterites is very much concerned with religion, and their birthrate is very high, the average family having ten children. This type of culture corresponds to the one Riesman et al. (1950) call inner-directed. We have seen in Chapter 30 that it is particularly the type of culture called by Riesman et al. other-directed that predisposes to schizophrenia.

Third, we can study whether a given culture confers a special type of symptomatology to schizophrenia.

Fourth, we can attempt to determine whether a given culture enhances the occurrence of some syndromes, related to schizophrenia, but not generally included in the schizophrenic category.

In the rest of this chapter we shall deal exclusively with the third and fourth aspects of the relationship between schizophrenia and culture.

II Differences in Symptomatology

Laubscher (1937) studied psychiatric disorders among the natives of South Africa. He reported that schizophrenic patients have hallucinations with magic, mythological content. The delusions are often grandiose in content (being a chief, a witch doctor). When they are of the persecutory type, they generally refer to the idea of being poisoned or bewitched.

Carothers (1947) studied mental illness in Kenya and gave a

great deal of importance to acculturation as an etiologic or predisposing factor. Only 11 (6.3 percent) of 174 cases of schizophrenia were suffering from the paranoid type. The paranoid minority had attempted Europeanization and had lived in a hostile, foreign environment. Tooth (1950) studied schizophrenia among natives of West Africa and did not find acculturation to be a psychogenic factor. The symptomatology, however, changed with education and acculturation. The bush people disclosed delusions that referred to their fetish systems.

Murphy and co-workers (1963), through questionnaires filled out in forty psychiatric centers all over the world, were able to obtain reports from African countries (Kenya, Union of South Africa, Nigeria, Uganda); Asiatic countries (Formosa, Japan, Java, Hong Kong, South Korea, India, Thailand); Australasia (Australia, New Zealand); North America (Canada, United States); South America (Brazil, Colombia, Chile, Peru, Ecuador); Middle East (Kuwait, Turkey); Europe (Bulgaria, Germany, Czechoslovakia, Norway); Caribbean islands (Barbados, Martinique). Delusions of destruction and religious delusions, so frequently described in the European literature, were very infrequent in Asian countries. Withdrawal was more frequent in East Asia, where

it is more acceptable than in European and American countries. However, whereas in Japanese and Okinawans withdrawal was frequently accompanied by flatness of affect and suicidal tendencies, among the Indians it was more frequently accompanied by catatonic rigidity, negativism, and stereotypy. Delusions of jealousy were more frequently reported in Asiatic countries. Simple schizophrenia was also more frequent in Asiatic countries. Catatonic signs were frequent among American Indians and mestizos; visual and tactile hallucinations were common in Arabian and African countries.

Pavicevic (1966) reported that Ethiopian schizophrenic patients are less aggressive and less dangerous to the attending personnel than European patients. Hallucinations and delusions are religiously colored; ideas of messianic mission and world recognition are also common among Ethiopian patients.

In Chapter 3 we reported that in the United States, too, the schizophrenic symptomatology has undergone noteworthy changes, presumably because of changes in the sociocultural environment. The catatonic and hebephrenic types are much less frequently observed. On the other hand, there seems to be an increase in the paranoid and

undifferentiated types. There seems also to be an increase in cases with mild, marginal, or subliminal symptomatology. Whether the increase is real or is an apparent consequence of the fact that mild cases in recent years have been more easily recognized and more easily treated is difficult to determine.

A change easily attributable to environmental conditions has been noted in the content of delusions of patients in Western countries. Whereas witchcraft and magic concepts have decreased, delusions involving electricity, radio, wiretapping, radar, television, and other modern devices have increased.

Sakurai and colleagues (1964) made an interesting study of the changing clinical picture of schizophrenia in Japan. They studied the clinical records of 1,127 hospitalized schizophrenics who were admitted in the psychiatric department of Kyushu University Hospital during one of the following periods: 1939-1941; 1947-1949; 1952-1954; and 1961-1963. The authors found that there has been a marked decrease in the incidence of catatonia, but little change in the incidence of hebephrenia. There has been little change in the incidence of auditory hallucinations, but a decrease in visual hallucinations.

Ideas of reference and delusions of persecution have remained at high incidence. Micromania (feeling that one's body or one part of the body is smaller), delusions of possession, metamorphosis, and expansive delusions have markedly declined. The authors suggest the following factors as the causes of such changes: changing value systems, changing family organization and parent-child relationships with consequent changes in personality, diffusion of mental health knowledge, expansion in social-welfare systems, and advances in treatment.

III

Syndromes Related to Schizophrenia occurring More Frequently in Foreign Countries than in the United States

Only a few of the related syndromes reported especially in the foreign psychiatric literature will be mentioned in this chapter. The question that promptly arises in several instances is whether we are dealing with different syndromes, different ways of classifying mental disorders, or emergence of special symptoms.

Bouffée Délirante

Bouffée délirante, or acute delusional attack, is described regularly in French textbooks of psychiatry and is also reported frequently in Haiti, where French culture (or psychiatry?) prevails. Ey, Bernard, and Brisset (1967) describe the *bouffées délirantes* as sudden explosions of transient delusional states that are polymorphic in their content and expression. The delusions may be persecutory in content, grandiose, sexual; they may refer to feelings of being possessed, influenced, having special powers, and so on. Hallucinations occur and in their content are related to the delusions.

The prognosis for the specific episode is good, but the possibility of recurrences is very strong. According to Ey and co-workers a patient who has had several *bouffées* risks becoming a schizophrenic. Ey acknowledges the fact that in many countries such syndromes are classified as “acute schizophrenia.” They are indeed classified in this way in the United States. However, special *bouffées délirantes* are reported in Haiti (Mars, 1955; Sanseigne and Desrosiers, 1961; Kiev, 1961), where they acquire a particular mystical, religious symptomatology with feelings of being possessed. According to Kiev (1969), in order to understand the Haitian *bouffée délirante* it is necessary to understand the role-playing aspect of the possession

phenomenon in Haitian culture and its characteristic manifestations in nonpsychotic individuals. According to Kiev (1969) some Haitian doctors, too, interpret the phenomenon in terms of spirit possession.

Capgras's Syndrome

Capgras's syndrome^[1] is a condition that has received great attention in the European literature, especially the French and Italian. In the American literature, Davidson (1941), Stem and MacNaughton (1945), and Todd (1957) have published articles on the subject.

In 1923, the French psychiatrist Capgras, in collaboration first with Reboul-Lachaux and later with several others, started a series of articles on what he called "*L'illusion des sosies*" (1923, 1924, 1925). *Sosie* is a French word meaning "double," a person who looks exactly like another one, just as an identical twin would resemble the other twin.^[2]

The phenomenon (or syndrome) described by Capgras is the following: the patient will claim, on meeting someone he knows well, that the person is a double or an impostor who has assumed this person's appearance. For example, the mother of a female patient

comes to visit the patient in the hospital. The patient claims that this visitor is not the mother but either a double of her or an impostor who has tried to assume the appearance of the mother in order to deceive the patient. The phenomenon is thus a complicated type of misidentification, much more characteristic and specific than the usual misidentifications occurring in schizophrenia.

Although the first publications reported cases of female patients only, a few cases among males have later been described.

Is this condition, described by Capgras, a special syndrome, or just a symptom occurring in one of the well-known clinical entities? The problem is controversial. Generally the French authors tend to give to Capgras's syndrome a special place in psychiatric nosology, whereas the German authors tend to see it as a symptom. From the cases reported in the literature, however, it is obvious that, although the patients presented other symptoms, this particular delusion of the double was the center of the symptomatology.

I have seen a few typical cases in American patients and have considered them as suffering from paranoid schizophrenia or

paranoid states. I am inclined to interpret also the cases described in the literature as cases of schizophrenia with a particular, unusual symptomatology. Capgras's syndrome thus should be more properly called Capgras's symptom. As a matter of fact, similar phenomena are described in the European literature in even rarer syndromes: for instance, the illusion of Fregoli, described by Courbon and Fail (1927). The patient identifies the persecutor successively in several persons—in the doctor, an attendant, a neighbor, a mailman, and so forth. The persecutor allegedly changes faces, as the famous European actor Fregoli used to do on the stage. Courbon and Tusques (1932) have also described the delusion of intermetamorphoses. The patient believes that the persons in his environment change with one another: A. becomes B., B. becomes C., C. becomes A., and so forth.

But, going back to Capgras's syndrome, several authors report that they have found the syndrome not only in schizophrenic-like or paranoid patients, but also in manic-depressives (Stem and MacNaughton, 1945; Todd, 1957).

Many patients reported in the literature have been treated with insulin or electric shock treatments, apparently with good results.

Others retained their delusions and illusions or had relapses.

Even if we deny recognition as a clinical entity to the Capgras phenomenon, it deserves further study from dynamic and formal points of view. The already abundant literature seems to be preoccupied almost exclusively with classificatory controversies.

Cargnello and Della Beffa (1955), reporting an existentialistic analysis of the phenomenon, write that, in the delusional experience of the patient, three persons enter: the patient, the *alter* (the other, the person who was well known to the patient), and the *alius* (the double or the impostor). They conclude that actually it is the *alius* who is lived intensely in the *Erlebnis* (lived experience) of the patient and, although misidentified, is the closest to the ego of the patient.

A few things seem obvious in this syndrome. First, the person whose existence is denied is a very important person in the life of the patient—for instance, the mother. The patient rejects the mother, actually attributes very bad habits to her, but cannot allow herself to become conscious of this rejection because of concomitant guilt feelings or other ambivalent attitudes. What the patient feels about the

mother is thus displaced to the double or impostor who allegedly assumes her appearance. Often the idea that the misidentified person is a double or an impostor occurs to the patient as a sudden illumination, or like the “psychotic insight” described in Chapter 22.

Capgras’s syndrome thus may be seen as an unusual form of psychotic displacement. All gradations of displacements occur from normal states to neuroses and psychoses. In private practice we often see how the young wife’s resentment toward her own mother is freely displaced and freely expressed to the mother-in-law, for whom she has no ambivalent feelings.

In Capgras’s syndrome the real person is spared the hate of the patient—even becomes sanctified, a model of virtue—and the impostor made the target. But the real person, the person whom Cargnello and Della Beffa call the *alter*, becomes a pale, peripheral figure. The patient is really concerned with the *alius*, the impostor.

More difficult than the dynamic is the formal understanding of the Capgras phenomenon. We know that very often in schizophrenia the opposite process takes place: persons and things that in thinking

processes should only be associated are identified. In the Capgras phenomenon, not only is there no increased tendency to identify, but a person who should be easily identified is *not*.

The real person is almost divided into two parts (the *alter* or the good part, and the *alius*, the bad part), just as often happens in dreams. In the Capgras phenomenon the persons are different, but the body has the same appearance. There is thus not only a denial of the Aristotelian first law of logic (law of identity)—*A is A*—but also at least an apparent denial of Von Domarus’s principle. That is, in spite of characteristics in common, the visitor is not the mother but an impostor. Obviously the mother is identified with the impostor, but this identification remains unconscious.

Why Capgras’s syndrome occurs (or is reported) more frequently in European countries than in the United States is a problem that still needs an explanation.

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,” “ticklish,” 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 frequent in men. Sometimes it has occurred in epidemic form.

Similar syndromes have been described in Siberia under the names of *myriachit* and *tara*; in Hokkaido (northern Japan) among the Ainu as *inu*; in Thailand as *bah-tschi*; in Burma as *yuan*; in the Philippines as *mali-mali*; Madagascar as *ramenajana*; in Nyasaland as *misala*; in Congo as *banga*. It has also been reported from Somaliland, the southern part of the Sahara, and from Tierra del Fuego without any particular name.

The patient, generally a middle-aged or elderly woman of dull intelligence and compliant character, becomes increasingly fearful and seclusive. The disorder may start with a sudden fright. Among the Ainu of northern Japan, the illness often begins when the patient has actually, or imagines having, seen or stepped on a snake. The patient may at first repeat some of his own words or sentences several times;

later on, he will repeat the words or sentences of other people, particularly of persons in authority. Still later, the patient, in a pantomime fashion, repeats or imitates gestures and acts of other people, even if this results in harm to himself. At other times he does the exact opposite of what other persons do. The next symptom is coprolalia. At first the patient utters incomprehensible sounds, which later become clearly obscene, or curse words that he never used before. The echolalia, echopraxia, and coprolalia are entirely uncontrollable.

Latah patients are often the butt of jokes. Adults and children may tease them until they tearfully beg to be left in peace or, less frequently, until they become violent.

In other parts of the world the *latah* syndrome acquires additional characteristics. In Africa the patients 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 in this case are usually males, become violent and present a picture similar to “running amok.”

The course of the disease is unpredictable. Some patients have become progressively worse, ending with a severe obsessive-compulsive neurosis or with a psychosis. In other cases, the symptomatology has remained static. The disease may run a paroxysmal course, with the paroxysms lasting for weeks or months.

Various interpretations of the *latah* syndrome have been attempted (see Yap, 1952, for a good bibliography and discussion). The *latah* patient is a compliant, self-effacing person who, even before becoming obviously ill, had tried to solve his conflicts by blotting out all expansiveness. *Latah* may be interpreted as an attempt of the patient to free himself of his anxieties by surrendering himself totally to others. The compulsive utterance of obscene words may indicate that he is not wholly successful in his endeavor. Frightened children often mimic other people. The mimicking may be a primitive anxiety-relieving mechanism that is still available to children and primitive people but not to adult Western man.

I have seen a few schizophrenics and especially preschizophrenics with a symptomatology reminiscent of *latah*. As mentioned in Chapter 6, I have interpreted these patients as

manifesting a variation of the stormy personality or other-directed personality—a variation perhaps made easier by special cultural factors. The patient is eagerly searching for object relations and identifications and tries to satisfy these tendencies in the most superficial, immature ways: identification becomes imitation.

Notes

- [1] For this section on Capgras's syndrome and for the one on latah, I have drawn liberally from the following articles of which I was a coauthor: (Arieti and Meth, 1959; Arieti and Bemporad, 1974).
- [2] The French work *sosie* derives from Plautus's play *Amphytreon*. In this play the god Mercury assumes the aspect of Sosia, servant of Amphytreon.

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