INTRODUCTION: THREE CASE REPORTS

Aneitin, a male in his early forties, shows many symptoms of schizophrenia. (He) not only lives alone but takes no part in Ifaluk society. In the past he had been dangerous. Periodically he became violent, shouted and screamed at people, and physically attacked them when they came near him (Spiro 1959:154).

Sadiya, a woman of about 35, had been a case of apparent schizophrenia. Shortly after the death of her mother [ten years prior to the report] Sadiya awoke screaming one morning and ran from the house. Her father caught her and beat her, but to no avail. The neighbors brought gifts and tried to calm her, but her speech remained meaningless and jumbled and she would run frantically through the village laughing wildly. She remained in this hopeless incapacitated condition for several months (Kennedy 1977 [orig. 1967]:380).

Juanita, a 14-year-old girl, came home from high school one day extremely agitated and then fled to a nearby town, pursued by her parents. . . . She was apprehended by the police [eventually and had to be] forcibly subdued and held . . . During the following weeks similar episodes were repeated. Eventually she had to be restrained by ropes in her house. [She was then hospitalized for one year and treated with electric shock.] Shortly after her return [home] she became violent again, attacking family members, ripping at her clothes, running in the street, insulting townspeople, and stealing from stores. . . .

Was Juanita really schizophrenic? . . . Juanita showed bizarre behavior of a relatively sudden onset that persisted at home, in the hospital, and at home again for several years. Her behavior seemed like that one sees in others who are called schizophrenic (Guthrie and Szanton 1976:147, 160).

The first of these case reports deals with a man on the atoll of Ifaluk in Micronesia, the second with a young woman in Nubia (Southern Egypt), and the third with a teenage girl in the Philippines. Similar accounts have been reported by anthropologists, psychiatrists, and others from all parts of the world. The implication is clear: mental disorders are to be found everywhere, in all societies and cultures, among all races, and in all geographic zones.

How have peoples everywhere dealt with this phenomenon? Are mental illnesses recognized? How are they explained? How are they treated? The reports from which the three examples are taken indicate that both Sadiya and Juanita were treated successfully by traditional healers. Are there disorders that exist only in certain societies? How frequent are mental disorders? These are some of the questions that will concern us in this chapter.

BACKGROUND

As we saw at the beginning of this book, culture and personality as a field of anthropology grew up in close contact with psychiatry, particularly with psychoanalysis. For example, Freud attempted to compare the complexes of neurotic patients with the ritual practices and beliefs of primitive peoples. In the early years of the century, too, questions were raised about whether mental illnesses existed in "Stone Age" populations, or whether they are a phenomenon of "civilization." The very question suggests a theory of mental disease: it was attributed to the fact that modern complex societies impose severe limitations on the satisfaction of individual impulses, which are subordinated to the social order. To the contrary, primitive societies, it was thought (on the basis more of imagination than information), allow the individual greater freedom for personal expression, and as a result, disorders that are seen in Western society would be absent.

Anthropological fieldwork soon revealed the erroneous character of these views. At present there exists a field of cultural psychiatry or psychiatric anthropology, and also a neighboring and partially overlapping field of transcultural psychiatry. Like cross-cultural psychology, which we dealt with in Chapter 6, transcultural psychiatry is largely a product of the second half of the twentieth century, when psychiatrists confronted unfamiliar situations in the developing areas of the world. For example, when the Australian physician B. G. Burton-Bradley went to Papua New Guinea, in 1959, he was that territory’s first psychiatrist, and for most the following decade and a half he was the only psychiatrist serving a population of two and one-half million people. His book, Stone Age Crisis (1975), describes what he found and how the life of the people of that territory changed in the period of his observation.
Social, cultural, and economic changes in the developing countries have created a need for psychiatric services for a number of reasons. Principal among them is the fact that disruptions of traditional life patterns have produced stresses leading to psychiatric illness in significant numbers of people. Among these stresses is the loss of the support of families or village communities by individuals who have moved to urban centers or who have gone to work in Western enterprises, such as mining centers or plantations. Also, as a result of the breakdown of traditional institutions under the impact of acculturation or westernization, traditional resources for dealing with disturbed individuals have become less available. At the same time, few psychiatrists have been working in developing areas, and they have frequently found themselves faced with an overwhelming task. On the one hand, there was the need to establish mental health services where none had been in existence, and often to do so with limited resources and inadequate personnel. On the other hand, there was the recognition that the cultural circumstances of patients must be understood in order to be able to provide a service that consisted of more than merely housing disturbed individuals who could not remain in the community. Psychiatrists in this situation developed means of communication with each other and also with anthropologists, who were often relied upon to provide information on the relevant cultural dimensions. In particular, two journals have grown up that play an important role in this network of communications: the Transcultural Psychiatric Research Review, published in Montreal, and Psychopathologie Africaine, published in Dakar (Senegal).

A series of topics have been at the core of debate and research in this area. On the one hand, there are questions concerning the definition, nature, and frequency of mental disorders, and the cultural factors relevant to them, as seen by psychiatrists and anthropologists using an absolute, or etic, approach. On the other hand, there are questions about the traditional systems of explanation and treatment of disturbances recognized as such in the various societies. Much of the research here centers on the activities of traditional healers and on possible explanations for their success. A third approach asks what roles certain emotional and cognitive states play in cultural life; we have taken a partial look at this question in our review of altered states of consciousness (Chapter 7). These researches are of both theoretical and practical interest. They affect the procedures used by specialists trained in Western medicine, and particularly psychiatry, in the developing areas and in at least some segments of our own society as well.

Although psychiatric anthropology is historically an outgrowth of culture and personality, it is now an integral part of the newer field of medical anthropology, which itself has largely grown out of culture and personality. It should be emphasized that when we consider traditional healing methods and theories, the distinction that is made in Western medicine between psychiatry and other branches of medicine is likely to be absent, and whatever the ailment, psychological dimensions appear to be relevant to a great many, if not all, treatment methods.

The Relativity of the "Normal"

Writing in 1934 for an audience of psychologists, Ruth Benedict remarked:

It does not matter what kind of "abnormality" we choose for illustration, those which indicate extreme instability, or those which are more in the nature of character traits like sadism or delusions of grandeur or of persecution, there are well described cultures in which these abnormals function with ease and with honor and apparently without danger or difficulty to the society (Benedict 1959 [orig. 1934]:263).

She goes on to illustrate how many traditional societies accept and pattern trance states that are considered abnormal in the West. At the same time she observes:

Western civilization allows and culturally honors gratifications of the ego which according to any absolute category would be regarded as abnormal. The portrayal of unbridled and arrogant egotists as family men, as officers of the law, and in business has been a favorite topic of novelists . . . Such individuals are probably mentally warped to a greater degree than any inmates of our institutions . . . They are extreme types of those personality configurations which our civilization fosters (Benedict 1959 [orig. 1934]:279).

In Benedict's view, then, neither social adequacy nor any absolute standards of normalcy are satisfactory criteria for mental health.

Almost half a century has passed since Benedict wrote this article. We have acquired a great deal of first-hand information on personality functioning and cultural patterns in all parts of the world. Yet the debate over criteria for mental health and mental illness has continued to rage. With some variations these two positions, decked out in ever new vocabularies, have continued to be defended.

Taking Benedict's findings into account, the historian of medicine, Erwin Ackerknecht (1943), distinguished between "autonormal" and "heteronormal," and between "autopathological" and "heteropathological." The "autonormal" individual is one who is considered normal in terms of his or her own society, as the "autopathological" individual is one who is considered abnormal or sick in these terms. On the other hand, the "heteronormal" individual is one who appears healthy to the foreign, scientific observer, and the "heteropathological" individual is one judged abnormal by these scientific standards. In other words, the psychiatrist, using universal standards of health, may arrive at a picture other than that of the individual's fellows, whose criteria for judging "normality" and "abnormality" may well be different.

This distinction raises another question: what if the standards of the society are themselves pathological? For example, Margaret Mead, in her autobiography, recalls her periods of research among several New Guinea peoples, and how she "loathed the Mundugumor culture with its endless aggressive rivalries, exploitation, and rejection of children" (1972:205). As a result of their complex kinship system and social structure, among these people,
Women wanted sons and men wanted daughters, and babies of the wrong sex were tossed into the river, still alive, wrapped in bark sheath. Someone might pull the bark container out of the water, inspect the sex of the baby, and cast it away again... It seemed clear to me that a culture that so repudiated children could not be a good culture, and the relationship between the harsh cultural prescribed style and the acts of individuals was only too obvious (Mead 1972:206).

Is it possible that a culture might be "wrong" and that, under such circumstances, the deviant individual, who does not conform to the social rules, might be less pathological than his peers? In the case of small, isolated, homogeneous societies, where individuals have little opportunity of being influenced by alternative models and few exposures to other ways of dealing with interpersonal relations, such a question may be idle. However, when we speak of large-scale, heterogeneous, complex societies it is quite another matter. The question was posed most acutely in the late 1930s and the years of World War II in regard to Nazi Germany. Had all the Germans gone mad? Could one claim that the sadomasochistic individual, at ease in this murderous regime, was a "normal" individual? Or, if normal in a statistical sense, could such a person be said to be healthy and well-adjusted? Such a situation clearly called for a closer look, for which cultural relativism was not enough.

A number of approaches to this problem have been suggested. Based on Clyde Kluckhohn's 1944 study of Navaho witchcraft, G. A. DeVos has proposed a distinction between "adaptation" and "adjustment." According to his usage, adaptation refers to social structure, and adjustment to "an ideal progression of maturation which is potential for all human beings. It is not culturally or situationally relative, but... may be culturally fostered or deformed" (DeVos 1976a:4). Adjustment, then, refers to personal maturation, in contrast to adaptation, which concerns behavioral responses to the social situation by individuals, and by groups through the development of special institutions. Witchcraft beliefs and possession trance cults may be examples of adaptive institutions that reveal tensions and stresses within the social fabric, which they are designed to ease.

Although psychiatrists have tended to view individuals in terms of adjustment and personal maturation, they also increasingly have become aware of the social context in which individuals function. Thus Rudolf Kaelbling (1961) could suggest that in any society there will be psychopathology when the individuals are unable to conform to the expectations of the community or to their own expectations. As DeVos has indicated, there is a great difference in diagnosis whether we focus on behavior as either conforming or deviant, or on personal maturation and development. By focusing on behavior, a group of sociologists has developed what has come to be known as "labeling theory," which claims that in Western society a person to whom the label of mental illness is attached is made to learn a special stigmatized role. In part, this view can be traced back to Ruth Benedict, for in the article quoted earlier she points out that in the United States homosexuality exposes an individual to all the conflicts to which aberrants are always exposed; yet these conflicts are matters of our culture, not universal and inherent in the tendency to homosexuality, as comparison with American Indian cultures shows. The psychological conflicts of the homosexual are, it is argued, added to the deviant behavior tendency. In the terminology of Lemert (1967), homosexuality would be termed a "primary deviance," and the neurotic conflicts many homosexuals experience would be termed "secondary deviance."

Because of the cultural relativist implications of labeling theory, Jane Murphy (1976) has sought to test it on the basis of data on mental illness from her research among the Eskimo of Alaska and the Yoruba of Nigeria. The information for these studies was collected by means of interviews and participant observation. In both of these cultures she found that there was a word, or label, for insanity. Descriptions of insane persons included reference to hallucinations, delusions, disorientation, and bizarre types of behavior, and resembled what would be called schizophrenia in Western societies. Murphy is careful to point out that the Eskimo and the Yoruba make a distinction between insane persons and those with special gifts or aptitudes to hear and see things that others do not perceive, to divine, to look into the future, and so on. Although there is occasional confusion among Westerners between pathological and visionary states, between madness and shamanism, such confusion does not appear to exist among the local people or their healing specialists. Murphy cited the example of the Eskimo shaman who is, temporarily, thought to be "out of his mind," something that can be learned and over which a certain control is exercised. As a result, the shaman's behavior is appropriate to his role and is executed only at appropriate times and places, and not continuously or spontaneously. The insane person lacks such control.

Relating her own data to the literature on mental illness in different cultures, Murphy concludes that the processes that produce disturbances of thought, feeling, and behavior in schizophrenia not only exist in most (if not all) cultures, but also are everywhere recognized and labeled. These constant underlying processes may be associated with culturally variable content. On the other hand, neither Yoruba nor Eskimo has a single word to cover what are called "neuroses" in Western psychiatry. They do, however, have large vocabularies dealing with specific forms of emotions, upsets, and disturbances. In both of these societies most emotional problems are considered to be types of illnesses that can be treated by a shaman or medicine man.

As far as the incidence of mental illness is concerned, statistics on schizophrenia in various societies show the rates to be very similar, ranging between 4.4 and 6.8 per 1000 population.

On the basis of these several findings, Murphy judges that labeling theory is off the mark:

Rather than being simply violations of the social norms of particular groups, as labeling theory suggests, symptoms of mental illness are manifestations of a type of affliction shared by virtually all mankind (Murphy 1976:1027).
Murphy's findings are consistent with those of an earlier study carried out by R. B. Edgerton among four East African tribes. He discovered (Edgerton 1966) not only that all four tribes had a concept of psychosis, but also that there was a high degree of agreement among them on the behaviors ascribed to "psychosis." Also, these behaviors are similar to those that are listed in Western countries, especially for schizophrenia. At the same time, Edgerton also found some intertribal differences. For example, the Kamba and the Hehe, who hold that psychosis is due to witchcraft, magic, or anger of the ancestors, also believe that psychosis can be cured and that patients therefore should be given treatment. The Sebei and the Pokot, on the other hand, who consider the condition to be an illness that comes about for no reason, hold that it is incurable and that patients should be treated harshly: tie them, let them starve, let them wander about, or even kill them. These responses, which were elicited by questionnaires among samples of the four tribes, indicate a relationship between beliefs about the causes of psychotic behavior, the expected outcome, and the attitudes toward treatment of patients.

CULTURE AND MENTAL DISORDERS

In view of Edgerton's and Murphy's findings, it may well be that labeling theory, at least in its strongest formulations, does not account for mental illness. There is, moreover, an increasingly accepted view according to which schizophrenia results from biological causes (Himwich 1971, Frohman and Gottlieb 1974). What, then, is the relationship between culture and mental disorder? Several such relationships have to be considered.

From the point of view of the psychiatrist, it is important to understand what kind of behavior is culturally patterned and what kinds of ideas are socially shared. It is easy to consider certain ideas "bizarre" because they are alien to the psychiatrist's own cultural background. We have already encountered a number of ideas that are widely accepted in certain societies but that seem strange to us: that it is desirable under certain circumstances to hallucinate or to believe that one is someone else ("possessed"), that some people can transform others into animals, and that dead people can be partially revived (zombies), to cite only a small number of examples. Whether or not an idea is "bizarre," then, will depend on a considerable extent on whether it is a unique and "deviant" personal product, or whether it is a socially shared belief. Moreover, beliefs influence actions, and to understand whether actions are bizarre, we must know how they are related to local beliefs, as well as to the personal, perhaps deviant, views that the individual may hold. At this point, however, the elaborations of beliefs, which may give rise to "secondary deviance," in the terminology of labeling theory, become relevant. Clearly, an individual can be said to be "possessed" only when the cultural group believes in possession and when, consequently, associates, seeing certain behavior, "recognize" the individual to be possessed. Where such beliefs do not exist as a social tradition, the individual has developed a personal pathological delusion, which results from emotional disturbance, not from learning the doctrines of a particular religious group.

For example, some years ago, the psychologist Milton Rokeach (1964) found that at the Michigan State Hospital in Ypsilanti there were three patients, each of whom claimed to be Christ. No one else shared their conviction, and their delusions were not matters of religious belief. The only cultural aspect in their personal madness was their acquaintance with Christianity and with the identity and the life of Jesus as told in the Gospels. This situation is quite different from certain other cases in which delusional individuals of forceful personality, and under appropriate circumstances, convert others to their views of reality, and as a result become cultural innovators. Mother Ann Lee, who founded the Shaker sect in England in the eighteenth century, was such a person. As a result of some difficulties with the authorities, she was in prison, and there she had a vision of Jesus, who revealed to her, she said, the duality of God as both male and female. Jesus, according to this account, incorporated the male aspect of the deity, or the Christ spirit, while Ann Lee was anointed by him to receive and incorporate its female aspect. According to White and Taylor (1904:21-22), who were themselves members of the Shaker sect, "henceforth Ann Lee was recognized among the humble band of 'poor in spirit,' 'pure in heart'... as the visible Head, the one in whom dwelt the Divine Mother." While we might consider her case in the context of psychopathology, her opponents in England considered her to be a sinner and a heretic. Like her followers, her opponents did not question the reality of her vision, they only questioned the source and the truth of the revelation. In doing so, however, they, as much as her followers, strengthened her own convictions. Leaving England with a small group, Ann Lee came to America where she founded a flourishing religious community, in spite of the fact her beliefs scandalized most Christians, and that she also imposed strict rules of celibacy and of communal property on all the converts. By all indications, she appears to have been a highly effective leader and organizer. Her own delusions were made the cornerstone of the group's beliefs.

A comparison among the Haitian possession trancer, the Christs of Ypsilanti, and Mother Ann Lee is quite instructive. The Haitian possession trancer is playing out a socially acceptable role on a ritual occasion, a role which she has learned and which includes both culturally stereotyped and personally idiosyncratic features. The role allows her to express certain personal stresses and some tensions in the group. Ann Lee, whose delusions had a basis in her personal history as well as in the troubled social conditions of her country, became a highly revered founder of a religious movement, who received respect, obedience, support, and love from her followers. In contrast to the clinical cases, she did not become a patient in a state hospital, and she was not made to give up her faith in the truth of her personal convictions. Instead, she converted others, who joined her in her view of herself and of the universe. The hospital patients were, in effect, punished for their convictions, whereas Ann Lee was rewarded for hers. The great
are not mentally ill, but are punished in Western-style psychiatric facilities, that can help them. Because they are witches however, that such patients are not usually hospitalized is twofold: on the one hand, they are not troublesome or agitated, so they do not come to the attention of their own emotional and cognitive distortions. Personal adaptation, then, may be, for certain exceptional individuals, not conformity to cultural standards but transformation of these standards. We shall come back to this problem in Chapter 9.

Another way in which cultural factors interest the psychiatrist concerns the nature of the stresses that members of a society experience, and that may be relevant to the occurrence of mental disorders in certain individuals. In this connection, it is important to identify individuals who, as a result of their social positions, are particularly vulnerable and experience greater pressures than others. For example, in speaking of the Zulu, we noted the highly stressful situation of young, newly married women; this special stress exists in many other societies as well, such as India or Japan. In many societies, too, high value is placed on a woman's having children, particularly male children. Inability to have children, or the death of young children, may precipitate illness in women who feel these pressures in addition to personal grief and loss.

An example comes from M. J. Field (1960), who reports that among the patients who came for help to possessed healers at shrines in rural Ghana, she saw numerous women who accused themselves of being witches. Most of them were middle-aged women whom Field, a psychiatrist, considered to be suffering from involutional depression. Although this ailment is not unknown in this country and in Europe, it has a special social and cultural background among the Akan-speaking peoples of Ghana. Here menopause is traumatic not only because, as everywhere, it indicates the end of child-bearing, but because of the social implications of this biological fact. Among these people, the production of children is the primary and continued purpose of marriage; since plural marriages are common, the cessation of child-bearing in one woman may well encourage a husband to take a new young wife to continue to father children. He may shower wealth as well as attention on such a young woman, to the disadvantage of the older wife. On the other hand, there is a shared belief in the existence of witches and in the possibility of being a witch without knowing it. That is, one may have the capacity to cause harm without conscious will or concrete action. Such women then accuse themselves of having caused illness or death or other disasters to their own children and to other kin. They explain their depression, restlessness, and inability to work, to eat, or to sleep as supernatural punishment for being a witch. Such patients rarely are seen in Western-style hospitals, so it often has been reported that depression as a mental disease does not exist in Africa. The reason, however, that such patients are not usually hospitalized is twofold: on the one hand, they are not troublesome or agitated, so they do not come to the attention of authorities, and they can be dealt with and maintained at home. On the other hand, there is the social opinion that holds, and that the patients share, that they are not mentally ill, but are punished sinners. Therefore it is the shrines, and not Western-style psychiatric facilities, that can help them. Because they are witches they must confess their sins.

Although Field does not offer any statistics, it appears from her information that in many instances such patients recover. Two factors seem to be relevant to this observation. First of all, in the United States, too, involutional depressions frequently show spontaneous remissions; that is, in time, whether or not anything special is done, patients often recover from this disorder. Secondly, in cases where the shrine priests (or their spirits) impose substantial fines in the form of sacrificial animals, they often must be paid by the patients' relatives. The willingness to make serious monetary sacrifices is a sign of positive support for the patient, which, in itself, may be therapeutic and help to reestablish the woman in a normal home situation.

Field sees a direct connection between witchcraft beliefs and depression, saying that witchcraft is kept alive [by depression] and the fantastic delusions of sin and guilt which beset the patients. Witchcraft meets ... the depressive's need to steep herself in irrational self-reproach and to denounce herself as unspeakably wicked (Field 1960:38).

Cultural belief and personal distortion thus tend to reinforce each other. That is, the culture provides a belief in witchcraft, and the patient applies the model to herself. In so doing, it should be added, she in turn becomes a model for others and also provides verification of the traditional belief for those who might be tempted to doubt its truth.

A further point, which Hallowell (1939) stressed with regard to public confession of sins among the Saulteaux, applies here as well, and indeed in all cultures where public confession of sin is required as part of the treatment of illness: The patient acts as a support of public morality. The confession makes the connection between sin and sickness evident to all those who hear the confession, showing that the wages of sin are, indeed, death or at least danger of death if pardon is not sought. In traditional societies, then, illness is not merely a problem of medicine but also a problem of the social order. The anthropologist, in contrast to the physician, therefore must understand the social control function of illness as well as the context of medical practice and belief. The two are often inseparable.

Uses of a Cross-Cultural Approach

On the basis of Western studies, numerous claims have been made concerning causes of mental disorders, stress-related diseases, and the reflection of such stresses in social pathologies, such as crime and interpersonal violence. Non-Western cultures may provide situations in which several factors that appear together in the West are separated. We have encountered several cases of this approach: Margaret Mead's early research on girls' adolescence in Samoa, Benedict's distinction between homosexuality among American Indians and in the United States, and our discussion of the Oedipus complex.
An example of such a cross-cultural test of direct relevance to mental health concerns the subject of residential crowding. Students of mammalian behavior as well as urban sociologists have argued that crowding produces stress and stress-related diseases such as essential hypertension, as well as juvenile delinquency and high rates of crime. Patricia Draper (1973) provides a test of this hypothesis in her work with the !Kung. Although these hunter-gatherers live in an arid and sparsely populated region, they construct their temporary settlements in such a way that they are as closely packed together as possible, with an average of less than 190 sq. ft. per person. This figure should be compared with the 350 sq. ft. per person recommended by the American Public Health Association. Furthermore, !Kung settlements are so constructed that the thirty to forty people who make up a group live in a single “room,” the central area of a circular campsite. The individual grass huts that form the outside “wall” of this site, face inward toward the living area and serve primarily for storage. Virtually all activity is public and occurs in a space shared by the camp community. The majority of the group is present in the camp at all times, and children are never alone. None of the dire consequences predicted for such conditions of human press appear among the !Kung, whose blood pressure is low and does not rise with age.

There are, of course, important differences between the !Kung and people who live in urban ghettos. One difference is that the !Kung, whether they stay in a given group or move to another one, are among relatives and friends, and have few occasions to encounter strangers. The context of the larger society in which urban crowding occurs is of major significance for an understanding of its effects. Crowding, identified simply in terms of a ratio of people to space, clearly appears to be inadequate as an explanatory variable.

Culture-Bound Syndromes

There long has been a debate among psychiatrists on whether or not there are mental disorders that exist only in certain specific societies. These disorders have been referred to as “culture-bound,” “exotic,” or “culture-reactive” syndromes or culture-specific disorders (see, for example, Yap 1969). We find description of diseases such as amok, arctic hysteria, imu, koro, latah, malgré, possession, windigo (or witiwa) psychosis, and many more. For the most part, these are local terms, employed in a specific group or region. The question that they pose is whether the patients’ behavior represents a specific syndrome (or group of symptoms) unknown elsewhere, or whether these are disorders familiar in other parts of the world, appearing exotic because of some specific elements of cultural content and local belief associated with them.

The problem may be illustrated by the example of amok, a Malay term that has entered the English language with a broader range of meaning. We may speak of someone as running amok when we wish to describe wild, aggressive behavior. Among Malay speakers, in a wide area of Southeast Asia (Western and Eastern Malaysia, Indonesia, and parts of the Philippines), it refers to a more highly stylized behavior. It is believed to occur typically among middle-aged men, following a period of brooding over an insult, and is characterized by a violent series of murderous attacks. The man suddenly seizes one of several traditional weapons, such as a kris (a jagged dagger), a spear, or a machete, and attacks any person or animal in his path. If he is not killed in an attempt to stop him, the attack will be followed by prolonged exhaustion and amnesia. The amok attack represents a response to shame and insult and thus a vigorous expression of male self-assertion; as such, it is a face-saving behavior. In terms of traditional belief, it may be accounted for by spirit possession or by magic; the community reacts to it with both fear and respect. In the medical literature, we find a variety of attempted explanations of amok, ranging from epilepsy, liver disorders, and infections to schizophrenia, hashish poisoning, and sunstroke.

Tan and Carr (1977) report on twenty-one cases classified as amok in a hospital in Western Malaysia. Ten of them were Malay men, who were familiar with the concept of amok, and whose amok attack fitted the cultural pattern closely. The remainder were non-Malays (Chinese and Indians), who were also hospitalized as a result of a fit of murderous rage; they, however, were not familiar with the concept, and their behavior was more idiosyncratic and variable. They had been classified as amok because the arresting policemen had been Malays and had so labeled them.

The majority of the older Malay men, who were the true amok, had longer hospital stays and remained symptom-free in spite of the fact that they received no treatment. Tan and Carr conclude:

Amok is a culturally (Malay) prescribed form of violent behavior, sanctioned by tradition as an appropriate response to a given set of conditions. It is not, per se, a disease, but a behavioral sequence that may be precipitated by any number of etiological factors, among them physical, psychological, and socio-cultural determinants (Tan and Carr 1977:65).

They question whether these untreated, nonrelapsing, long-term patients are, or ever were, psychotic. Since these patients were older men and had been hospitalized for a long time, these authors find support in their study for the claim by H. M. B. Murphy (1973), that classical cases of amok are decreasing in frequency, and that amok as a syndrome has undergone a variety of changes, with new social conditions producing new forms of deviant behavior.

The so-called culture-specific disorder that has created the most discussion is that referred to as the “possession syndrome.” Wallace (1959) has spoken of possession as “that perennial flower of confusion.” The confusion is due to several causes. The first among them is that, unlike the other syndromes in our list, possession is a concept that is familiar in the Judeo-Christian tradition. The cases cited in the New Testament, in which Jesus drove demons out of various kinds of sufferers, have long served as models for pathological behavior of a hysterical
type. The similarity between such cases of "possession" and hysterical patients in a clinical context was recognized by the nineteenth century French psychiatrist Charcot and his students, who took a great interest in the literature of the past that described cases of possession. The Christian churches have continued to admit the possibility of demonic possession and exorcism, and there has been a certain revival of interest in this subject in recent years, encouraged in part by spectacular movie productions.4

A second source of confusion lies in the fact that, as we saw in Chapter 7, belief in some form of possession is widespread. Consequently, we are dealing not with a local phenomenon, but with a multiform notion with a virtually worldwide distribution. The unfortunate result is that people often erroneously think that what they recognize as possession is likely to be the same condition that someone else, in another part of the world, means by that term.

L. Langness (1976) has proposed that all the so-called culture-bound syndromes, including "possession," regardless of their local trappings, be considered as manifestations of a single type of disorder, for which he suggests the term hysterical psychosis. Moreover, he argues that the term "possession" should be used only for intentionally induced, ritual states (of the type we discussed at length in Chapter 7), and not for psychiatric disorders. He points out that psychiatric disorders, by whatever name they might go locally, are considered abnormal by the people themselves, whereas intentionally induced ritual possession is an institutionalized form of ritual behavior. Ritual possession is a sacred part of religion, and hysterical psychoses are profane. So far this suggestion is uncontroversial. However, Langness further argues that hysterical psychoses and positive, ritually induced possession are "functionally equivalent," serving the same purpose, so we should expect to find that when one is present in a given society, the other will be absent.

The ritual states Langness speaks of, and for which he wishes to reserve the term "possession," are well illustrated by possession trance as it occurs in the context of Haitian vodou. The negative, pathological cases are illustrated by a report from Northern India, published by Stanley Freed and Ruth Freed (1964). The patient was a fifteen-year-old girl, recently married, who was "possessed" by a ghost. The Freeds consider her condition a hysterical attack, involving temporary loss of consciousness, shivering and convulsions, and complaints of various physical symptoms. The precipitating cause of the incident appears to have been her new role as a wife, which caused a separation from her family, entry into a large group of strangers from whom she could expect little support, and her conflicts over sexual relations. The Freeds, following the psychiatric literature, distinguish between two kinds of "gains" the patient obtains from hysterical attacks: a "primary" gain is the relief of the unconscious psychic tensions; the "secondary" gains involve a modification and manipulation of the situation in which the patient finds herself, to increase the sympathy and support she receives from her new relatives.

The Freeds' patient was treated by local curers. In some cases such cures fail, and patients are brought to hospitals. Teja and his associates (1970) saw fifteen such cases in two Indian hospitals. According to them, the typical "possession" case is a woman in her twenties, of low education and low income. Of the thirteen who were women, the psychiatrists diagnosed six as hysteria, five as schizophrenia, and two as mania. Nonetheless, they argue for a category of "hysterical possession states" because of the cultural content and context, which very closely parallels that described by the Freeds.

These reports support Langness' argument that the term "possession syndrome" tells us little about the psychodynamics of such cases but only identifies something about the local belief system. Indeed, one might go further, for the precise local content of beliefs varies considerably. Thus, in their comparison of their own case with cases reported from other parts of Northern India, the Freeds note a number of differences both in the actual symptoms and in the beliefs concerning the possession. In an area they call Shanti Nagar, the Freeds found that spirit possession always involves individuals who are close relatives, whereas in Uttar Pradesh, another area of Northern India, the rituals in honor of the goddess Kali even have been maintained in Guyana by Indian immigrants (Rauf 1965, Opler 1958). They are frequently nonrelatives. Cases of possession in Uttar Pradesh typically involve accusations of witchcraft and aggressive behavior. More important, in Uttar Pradesh a great variety of illnesses and misfortunes are attributed to spirit possession, and not merely possession trance attacks or seizures. However, the shaman may induce such an attack in order to question the spirit who is supposed to be causing the trouble.

This comparison suggests that even in Northern India there is no single concept of possession illness, but regional variations in the beliefs, the associated behavior, and most importantly, in the disorders that reference to possession by ghosts covers. In other words, in any area where a "possession" illness is reported, we have an emic category of illness, which may well cut across Western categories of disease. This fact is an important limitation on Langness' suggestion, for where barrenness is attributed to spirit possession we are likely to be dealing with something other than a hysterical psychosis.

In India we also find a great many different types of ritual, institutionalized possession trance cults with possessed curers (or shamans) playing a large role (for example, Harper 1957, Montgomery 1975, Prince 1976). Some of these rituals in honor of the goddess Kali even have been maintained in Guyana by Indian immigrants (Rauf 1965, Singer et al. 1975). This fact suggests that the hypotheses concerning the functional equivalence of hysterical psychoses and ritualized possession trance should be reformulated.

Moreover, the negatively evaluated, spontaneous, pathological type of so-called possession, is not easily and rigorously separated from the positive, intentionally induced ritual states. In a large number of societies a negative, apparently pathological state, interpreted as due to possession by a spirit, precedes initiation into a therapeutic cult, after which the "possession" occurs only at appropriate times,
during rituals when the spirit specifically is invited to become manifest. We referred earlier to the widespread zar cult, and the cult of diviners among Zulu women. In other words, in many instances a pathological "possession" of the type that might well fit the definition of a hysterical psychosis is transformed into a ritualized possession trance as a result of a therapeutic initiation.

This connection may apply also to certain culture-bound syndromes that are not labeled "possession" in the ethnographic and psychiatric literature but are known by various local names. Kerry Stroup (n.d.) has reviewed the reports on one such syndrome, called imu. Imu is a hysterical disorder among the Ainu of Northern Japan, most of the cases reported occurring among women. Imu is similar to latah, which is a Malay term, and also to certain forms of arctic hysteria reported from Asiatic Russia. All of these disorders have a number of features in common: compulsive copying behavior, including repeating or echoing the speech of others (echolalia) and the actions of others (echopraxia), and the compulsive use of filthy speech (coprolalia). Such individuals also are characterized by great suggestibility; they are easily startled and often teased by others, thus provoking an attack, which is considered to be amusing. In addition, in imu, according to local belief, there is some connection with snakes: a snake spirit is thought to possess the woman, and an image of a snake is used in an exorcistic healing ritual. Among the Ainu there are also female mediums, who serve as diviners to identify causes of illness, and who are the assistants of male healers. They are women who suffered from imu in their youth and were put through special healing rituals (Kitigawa 1960). Thus this particular dissociational illness may, for some individuals, be a first stage in the acquisition of a valued cultural role, open only to a few women in this male-dominated society.

A radical distinction between ritualized possession trance and the hysterical psychoses, such as that suggested by Langness, would also imply that, upon individual evaluation, one would find participants in the cults to be well-adjusted individuals. Such evaluations have been carried out relatively rarely. Before we turn to some of this information, it might be useful to consider several distinctions among the ways in which possession trance is used in ritual contexts. For example, one might expect to find differences between cultures in which possession cult roles are highly stereotyped and those in which they allow a good deal of room for the expression of individual needs through the supposed voice and behavior of the spirits. This latitude includes the number of spirits a person may be possessed by, or in psychological language, the number of alternate personalities an individual may develop and the degree to which they may be differentiated.

An example of a highly stereotyped possession is presented by Robin Horton (1969) from the Kalabari region of Nigeria. Here male priests of the cult of the founding heroes are possessed during a special annual festival. Horton notes that the men who are the priests had been identified by diviners when the position had fallen vacant. They had not received a "call" either through illness or spontaneous possession trance or in some other manner. Individuals might be reluctant to accept the charge because of the many restrictions and difficult duties associated with the office, but they would accept when illness or misfortunes were interpreted as the result of such reluctance. Moreover, there was no training for the role. The behavior of possession trance was highly stereotyped and, in a way, dangerous. Seeking to evaluate the psychological elements in this situation, Horton concludes that in this case it is more a matter of society imposing its will on an individual, than of an individual using peculiar behavior to adjust to society. [To obtain] intermittent dramatic appearances of its guardian spirits [the community] commandeer the bodies of certain of its members. It does so without any obvious reference to the psychic suitability of the individuals concerned. [Yet] it seems able, despite these apparently unpromising conditions, to force genuine dissociation upon those whom it selects (Horton 1969:24–25).

At the other extreme, there is the case of Haitian vodou, in which individuals may be possessed by several different personalities, and in which they have a good deal of latitude in what they say and do, which permits them, in many instances, not only to act as healers or diviners, but also to further their own ends. For example, I have reported elsewhere (Bourguignon 1965) how a young woman was possessed by a female spirit who demanded that the young woman's common-law husband marry both the possessing spirit (in a vodou ceremony) and the spirit's "horse," the young woman herself (under Haitian law), in order to be healed of a psychotic episode. Clearly, the "horse's" personal wishes were relevant to this therapeutic method; she was able to give expression to her unconscious wishes, through the voice of a possessing spirit. Individuals, in this way, can use possession by spirits to manipulate their social environments. In that sense, it has positive value for an individual living in a socially highly restrictive environment. I have referred to possession in this context as "regression in the service of the self."

The Brazilian psychiatrist, René Ribeiro (1956), who has spent many years studying Xangô cult groups in Recife, Pernambuco (Brazil), reports that the psychic status of individual participants in these cults varies widely. He notes that for some individuals participation in the cult is therapeutic and helps them in dealing with their problems, whereas for others it is an expression of their disorders.

There are also differences between individuals who join such groups in order to be cured and those who join for other reasons, if the cult is so organized that various reasons exist for seeking admission. Even among those who come for cures there will be differences in psychological status related to the progress of the cure. Furthermore, there are likely to be important differences between leaders of such groups and rank-and-file members. We have more detailed individual psychiatric evaluations of cult leaders or shamans than on cult members. Joan Koss (n.d.) points out that Puerto Rican spiritist healers vary considerably in personality adjustment. The same is reported by Yuji Sasaki (1969) for Japanese shamans. Boyer (1962, Boyer et al. 1964) on the basis of Rorschach tests and
suggests three important points. First, in many instances we are dealing with a traditional, or native, concept of illness, which includes what to a Western, medical observer are a number of diverse ailments or disturbances.

Some Possible Causes of Culture-Bound Syndromes. The psychological mechanism that is involved in possession trance is dissociation. M. J. Field defines it as "a mental mechanism whereby a split-off part of the personality temporarily possesses the entire field of consciousness" (1960:19).

Such dissociation is characteristic of hysteria, which, however, has other features as well. Some psychiatrists who have worked among people where possession trance specialists are found, such as Field (1960) and Pfeiffer (1971), emphasize that dissociation is not necessarily pathological. However, even though learning is sometimes obviously involved in the development of this type of behavior, there is good reason to think that individuals who have a propensity for dissociational reactions are characterized by hysteroid personalities. As La Barre (1975:41) has pointed out,

psychodynamically, "possession" is not so much an invasion by an alien psyche as it is the overwhelming of conscious ego functions by ego-alien primary-process mentation... (italics in original).

In other words, the secondary personality, which is believed to be a spirit entity, is a part of the individual's own personality that is not recognized or faced. In the context of shamanism or of possession trance cults, the person's ego, the rational practical aspects of the personality, can make use of these split-off tendencies in support of the individual and of the community. On the other hand, we must not lose sight of the fact that even in individuals who suffer from hysterical psychoses, there will be a substantial cultural content and a cultural context that structures both the patient's behavior and the response with which the social group meets this aberrant behavior.

It is possible that at least some of the culture-bound syndromes have organic or ecological origins. This kind of cause may at least constitute one aspect of arctic hysteria in North America. Wallace (1972) has suggested that the behavior may be due to a calcium deficiency, and Foulks (1972), who has pursued the matter in the field in Alaska, has pointed to the drastic annual variation in daylight as a possible ecological factor relevant to these behavioral and emotional disturbances. Similarly, as we have seen, Gussler (1973) has suggested a convergence of ecological and psychocultural factors in the development of possession trance illness among Zulu women.

Summary. A survey of the literature on the so-called culture-bound syndromes suggests three important points. First, in many instances we are dealing with a traditional, or native, concept of illness, which includes what to a Western, medical observer are a number of diverse ailments or disturbances. It is helpful to understand these categories if we wish to understand how emic medical sys-

tems work. However, they are not helpful if we wish to diagnose ailments in terms of a supracultural scientific diagnostic system, in order to understand whether the same psychodynamic processes are at work in all human groups.

Second, at least some of the ailments covered by the term "culture-bound syndromes" share the characteristics of hysterical psychoses. However, in any specific case this similarity cannot be assumed; the diagnosis must be verified clinically.

Third, ailments that are recognizable in an absolute diagnostic system are nonetheless likely to have some specific local "coloring," that is, to have cultural features that modify the clinical picture of a disorder. We have noted this modification, for example, in the case of involutional depression in Ghana.

TRADITIONAL HEALERS AND HEALING SYSTEMS

We have seen that the so-called culture-bound syndromes started out as emic disease categories, and through contact with Western medicine, have been turned, at times, into special diagnostic categories. Native categories such as latah and amok may indeed be only fragments of complex traditional medical systems.

The most complete description of a traditional system of classification, explanation, and treatment of mental disorders has been published by George Devereux (1961), for the Mohave Indians. He himself speaks of it as a "kind of Mohave textbook of psychiatry," dictated to him by Mohave specialists. The Mohave shamans recognize a great range of disorders and often explain the difference between their views and those of Mohave laymen. Some disorders may be due to various kinds of aggression; others are disorders of the sexual impulse and what Devereux calls "mood disturbances"; there are also disorders caused by such external agents as witches and ghosts. Traditionally, the Mohave were hunters and warriors, so disorders resulting from aggression interestingly reveal the unconscious guilt such behavior produces. Members of war parties, for example, were believed to be exposed to dangerous influences, which might cause insanity, emanating from new scalps, prisoners, and aliens. This notion of danger even was expanded in more recent times to include Mohave Indians who have served in the U.S. Armed Forces. Anxiety over killing, however, might also appear in hunters who had eaten their own kill, as well as in individuals who had killed witches to free the community from them. Contacts with aliens and enemy ghosts also were considered dangerous. Mohave psychiatry is both supernaturalistic and psychological. It is part of a world view in which various supernatural beings and forces (ghosts, witches, dreams) are active and dangerous; it is psychological in seeking to understand individual emotions and motivations.

Theories of disease, and specifically, mental disease, are related to a general world view, to the beings and forces that are believed to exist and to their supposed connections with human beings and their state of health and prosperity. As such, in traditional societies, medical systems are part of larger religious
systems. Moreover, therapeutic systems are related to theories of disease. Thus, if disease is due to infractions of taboos or social rules, it is punishment for such infractions, and the appropriate therapy will involve confession. La Barre (1964) has discussed at some length how confession works as cathartic therapy among many American Indian tribes. As these tribes have undergone drastic cultural changes, confession has taken on new forms, appearing in the context of the Peyote Cult and the Native American Church. Hallowell (1976 [orig. 1963b]) has shown how confession serves not only to relieve the guilt of sinners, but also to maintain social sanctions among the Saulteaux, a society without chiefs, judges, and courts. A. F. C. Wallace (1958) has discussed how psychotherapy through catharsis worked among the Iroquois by interpreting dreams as "wishes of the soul" and of supernaturals who appeared in, or sent, the dreams. Every effort was made to satisfy these wishes, as they were understood. In the eighteenth century, Iroquois society underwent great disruptions, resulting in demoralization, drunkenness, and social disorganization. They were rescued from this state by a new religion founded by Handsome Lake, a visionary prophet, himself a former alcoholic. In this new system, Wallace tells us, emphasis was placed on control, and confession of sins was used in this context. On the basis of his historical research, Wallace has proposed a more general hypothesis that should be important for cross-cultural studies:

in a highly organized sociocultural system, the psychotherapeutic needs of individuals will tend to center in catharsis (the expression of suppressed or repressed wishes in socially non-disturbing ritual situations); ... in a relatively poorly organized system, the psychotherapeutic needs will center in control (the development of a coherent image of self-and-world and the repression of incongruent motifs and beliefs) (Wallace 1958:94).

Anthropologists have long attempted to account for the successes of traditional healers. They have observed cures, and they have noted people's confidence and faith in these practitioners. Indeed, it often has been reported that shamans and other healers consult their own colleagues in time of sickness, which suggests that they themselves have confidence in the techniques they practice. For the most part, anthropologists have dealt with specific societies, often with specific episodes of illness and curing, and only rarely have they attempted to make broader generalizations.

For example, in a fascinating paper, Victor Turner (1964) describes in some detail the illness and cure of an individual among the narrow of Zambia. Turner points out that among these people the illness of a single individual is often seen as expressing disharmony not only within the patient, but also within the patient's group, and it is the task of the diviner to rearrange the group, to restore harmony to it. In the specific case, the illness was explained, through divination, as resulting from the anger of an ancestral spirit. There was a good deal of conflict among the relatives of the patient, and a major portion of the healing ritual was devoted to the confession of ill feelings toward the patient by various persons and to his own expression of grudges against others. In addition, much magical ritual was carried out, including the slight-of-hand extraction from the patient's body of a tooth, which, supposedly, the afflicting ancestor had sent into the patient to trouble him. After the sequence of rituals, which apparently improved the patient's condition, moreover, certain individuals moved away from the village, so the social group was reorganized. As Turner points out, "the sick individual . . . is reintegrated, into his group, step by step, as members are reconciled with one another in emotionally charged circumstances" (Turner 1964:262). The social group is rebuilt, and relations among its members are modified. In a larger scheme of things, relations between the living and the dead ancestors are also altered. At the same time, there is not only social manipulation but also a dramatic manipulation of the emotions, through the confessions that "clear the air" and through the various symbolic, ritual actions. Both the patient and the body politic are healed.

Among the many diverse elements in the curing process that have been reported from societies in all parts of the world, several common features stand out. They may be summed up in two terms: "symbols" and "rituals." In a famous paper, Claude Lévi-Strauss (1963) has spoken of the "effectiveness of symbols," comparing the procedures used by the shaman among the Cuna Indians of Panama to those of the psychoanalyst. The shaman uses a special telling of a myth to help a woman in a difficult delivery. The myth follows the birth process in great detail, and Lévi-Strauss suggests that it is helpful in that it guides the woman, focusing her attention on her body and increasing her awareness of what is going on within her. The psychoanalyst, similarly, helps the patient become conscious of what is going on within, psychologically rather than physiologically. More recent relaxation techniques are even more similar to that of the Cuna shaman.

A. F. C. Wallace (1966), as mentioned earlier, considered ritual as a process of unlearning and relearning; indeed, he speaks of a "ritual transformation of experience" and thus of a transformation of the individual. Kiefer and Cowan (n.d.) more recently have looked to psychological experiments for analogies with rituals. Experiments that use drug-induced altered states of consciousness have shown that alterations of consciousness have an effect on the storing and remembering of information. (This effect has been referred to as "state-dependent learning.") Also, the total context in which information is acquired has a great effect on ability to recall it. Rituals are situations that provide special contexts of behavior, with heightened meaning and emotional intensity. Awareness or consciousness is modified in such settings, even if no altered state is specifically induced. Ritual, therefore, provides an ideal setting for the unlearning of faulty forms of adjustment and for the learning of more adaptive forms. Ritual situations heighten patients' suggestibility by the great attention that is paid to them, the use of symbols, the support of supernatural authorities, and so on.

The British psychiatrist, William Sargant, basing his work on the work of the Russian physiologist Pavlov, has defended the thesis that extreme emotional
excitement helps the individual to unlearn and forget old ways of feeling and, again in the setting of heightened suggestibility, to learn new desired responses. He has applied this thesis to political conversion ("brainwashing") and to religious conversion ("possession") (Sargent 1959 [orig. 1957], 1974).

A number of comparisons have been made also between the procedures used by native healers and by modern psychiatrists. For example, the Canadian psychiatrist, Raymond Prince, has reported the different kinds of Yoruba healers and healing methods in an article (1964) and in a documentary film. He speaks of traditional healers in charge of treatment centers, diviners, possession trance cults, and men's secret societies (or "masquerade cults"). Both physiological and psychotherapeutic elements are used in the healing process. Both are generally employed in a magico-religious context that involves beliefs in the activities of witches, ancestor spirits, and gods. A great deal of ritual is employed. Among the physiological elements is the drug rauwolfia, a powerful tranquilizer, which has been known in West Africa for hundreds of years. However, a species of rauwolfia was introduced into Western medicine, from India, only in the last quarter century. Prince identifies a series of psychotherapeutic elements in Yoruba practice: suggestion on many different levels, from the most symbolic and metaphorical to direct commands; the use of sacrificial animals, which may contain a "sacramental" element (the identification of the patient with the animal and the substitution of the animal for the patient in the "paying off" of angry spirits); manipulation of the environment, (such as an order to move to a different neighborhood or to change occupations); and "ego-strengthening elements" (such as the requirement to join the ancestor cult, which might provide the patient with greater self-confidence by offering assurance of the spirits' protection). Prince also sees parallels to Western group therapy in the possession trance cults and in the men's secret societies; by joining them, the patient gains the support of a group of peers. Also, as we mentioned earlier, such cult groups provide sanctions for behavior that is prohibited under ordinary circumstances. As a result, it becomes possible for the patient to act out personality aspects that normally have to be repressed, or whose expression is punished in ordinary life situations. For example, women temporarily may act out roles of men, and men those of women. Taboosed aggressive and sexual behavior may be engaged in, because responsibility for it is assigned to the spirits.

Although Prince points to a number of similarities between Western psychiatry and the methods of the native healers (the use of drugs, sometimes of intentional suggestion and command, and more generally of suggestion and command as part of the total medical setting), he also points to one major difference: Western psychotherapies attempt to help the patient gain "insight"—understanding of the unconscious strivings that influence behavior—and to help integrate repressed elements, such as those expressed in dissociation states, into the personality. The Western psychotherapist's aim, then, is not merely to reduce symptoms and to help the individual to function in society, but to reach greater emotional health and maturity. There is little evidence that any of the traditional therapies seek to do so.

**How Successful Are Traditional Healers?**

This difference in aims between Western psychotherapists and traditional healers raises a number of interesting questions. Foremost is the question of just how successful traditional healers actually are. Anthropologists and psychiatrists, as we have seen, have considered at some length how traditional healers work and how their actions may alleviate the sufferings of the patient. However, there is little hard evidence of their rate of success. Moreover, as Prince (1979a) has pointed out, we have little reliable data to show that Western psychotherapies "work" either. In this context there are at least two different problems: on the one hand, how do we define a "cure"? As we have just seen, there is quite a difference among the goals therapists set for themselves: the removal of symptoms, the reintegration of the patient into the community, and emotional growth and maturation are just some of these goals. On the other hand, adequate statistics are hard to come by. Even in industrialized societies the most readily available statistics, hospital admissions and discharges, are open to a variety of interpretations.

When we ask the patients about their cures, we sometimes discover another aspect of the problem. J. Monfouga-Nicolas (1972) studied the Bori possession trance cult among the Hausa people of Niger, West Africa. This is a cult of women, who join because of various kinds of illnesses. Although the cult leaders distinguish fifteen kinds of "madness," patients suffering from them are only a small minority, with others coming to the cult because of frequent miscarriages, sterility, and various other troubles. Because the author had no medical diagnosis available to her, the precise nature of illnesses and the relative contributions of psychological and organic elements to the complaints are not known. She says that members are considered "cured"; however, this claim has to be understood in their sense. For them, illness is related to guilt, and initiation permits the externalization of this guilt and thereby the removal of the self-destructive tendencies associated with guilt. Consequently, even if physical symptoms continue to exist, their meaning has changed. This outcome is remarkably similar to what a U.S. sociologist, E. Mansell Pattison (1974), found among patients who were converts to fundamentalism: they felt "healed" even though they might not have lost their disease symptoms, and even might continue to seek medical treatment at the same time. The faith healing increased the strength of their religious beliefs, so Pattison concludes: "Faith healing is not an exercise in the treatment of organic pathology, but an exercise in the treatment of life style" (1974:451). Like the Bori adepts studied by Monfouga-Nicolas, and like members of possession cults around the world, these U.S. Protestants belonged to groups that gave them intense emotional support. Also, like the other cultists, they experienced altered
states of consciousness, which found their expression in glossolalia ("speaking in tongues") and other ecstatic states, referred to as "gifts of the Spirit."

As far as the Hausa women are concerned, the French psychiatrist J. Broustra (1972) suggests that the Bori cult treats individuals suffering from neuroses and psychosomatic symptoms. True insanity, by contrast, is the specialty of healers who rely on an extensive knowledge of plant remedies. One of these specialists who, according to Broustra, probably treated no more than one hundred cases in a career spanning a period of twenty years, reported that he had better success with some types of cases than others.

As mentioned before, we have limited information on the actual success rate of native healers. However, it appears that the greatest success occurs in cases with physical symptoms that have a strong element of emotional involvement. For example, Vincent Crapanzano studied the Moroccan curing cult called Hamadsha. He says of their healers that they are able to produce, "often dramatically, the remission of symptom—paralysis, mutism, sudden blindness, severe depression, nervous palpitations, paraesthesias, and possession" (1973:4). According to this author, many of the disorders treated successfully by making the patient a member of the cult represent bodily expressions of guilt reactions. Once the patient has joined, it is believed that a failure to obey the command of the spirits will cause a relapse, and conversely, if a relapse does occur it will be explained as punishment for a transgression. This situation is similar to that in the Bori cult of the Hausa and in the zar cult of Ethiopia, Somalia, the Sudan, and Egypt.

In spite of the reports of successes of this type, some other accounts suggest that such treatments may not be without their dangers. B. Lewin (1957) presents an interesting case history from his psychiatric practice in Egypt. The patient was a woman who was brought to him suffering from a severe depression. She was childless, and concerned over her condition, she had sought the help of a zar cult leader. This specialist explained that a spirit was causing the patient’s infertility and that to satisfy him it would be necessary for her to join the cult. Once she had joined and was assured that the spirit would no longer keep her from having children, she began to show signs of pregnancy. However, when she was examined at a prenatal clinic, she was told that she was not pregnant. The patient refused to believe this diagnosis, and her false pregnancy continued for the full term. When she did not have a baby, however, she again returned to the zar specialist, who said that the spirit (jinn) had been jealous and had stolen the child. At this point she came to the psychiatrist.

There are several interesting aspects in this situation. We do not know why the woman was infertile, but clearly this fact represented a cause not only of sadness and disappointment to her, but also of great fear. It must be remembered that under Moslem law a husband may divorce a wife for failure to have children. In this state of mind she came to see the zar healer. Here she received not only a meaningful explanation but also a method of dealing with her problem. The ritual process and the strong suggestion from the healer, together with her own great desire to have a child, led her, however, not to conceive a child, but to a hysterical pregnancy. The ritual cure, instead of solving the problem, had, in fact, created a new one! The zar healer, however, was not at a loss to account for the strange situation, and offered another supernatural explanation consistent with the first. "Cures," then, may produce positive results, but, as this case shows, they also may be dangerous.

Another interesting aspect of this case is that we are dealing with a woman in a developing country, where several different kinds of services are available: on the one hand, there is the traditional sector represented by the zar healer, and on the other hand, there is the modern sector represented by the prenatal clinic and the psychiatrist. Depending on their specific difficulties, patients may use services in both of these sectors, either at the same time or in succession.

This is an exceptional case, in that there is not only a dramatic failure of the healing process, but also information available through a psychiatrist. To evaluate the procedures of traditional healers, we need medical diagnoses and long-term follow-up studies, not merely descriptions of what the healer does and accounts of short-term remissions in a few cases.

One such detailed study has been published by W. G. Jilek (1974), who worked as a psychiatrist and physician among the Coastal Salish Indians of British Columbia for some six years. Among these people, an ancient spirit cult has been revived in recent years, in modified form, and has become a healing cult. According to Jilek, there are among the Coastal Salish numerous individuals who suffer from what he calls "anomic depression," that is, depression linked to social and cultural disruption. This depression is shown in aggressive and antisocial behavior, alcoholism, drug addiction, depression, anxiety, and various bodily complaints. Jilek links these disorders directly to the marginal status of the Salish in white society, and to the social and personal conflicts produced by acculturation. The Salish speak of such cases as resulting from "spirit illness," for which white medicine has no proper cure. The guardian spirit ceremonies have become rituals of identity change. As often happens in initiation rites, the novice is ritually, symbolically, slain and reborn. In this process he loses his old identity as a marginal individual and is revived with a proud new Indian identity.

This ritual process, which lasts several days, includes a number of different stages, some public and some private. It includes inducing altered states of consciousness, fasting, having a vision of the guardian spirit, and acquiring a spirit song and spirit dance. These activities are followed by a period of indoctrination and finally, by a great, strenuous, public dance. Afterwards, the new members continue to participate in the ceremonies during each winter season. That is, they join the group on a permanent basis.

Jilek reports that of twenty-four patients, all but three showed varying degrees of improvement either in their symptoms or in their behavior. Some of these individuals had long-term problems; they had received unsuccessful medical treatment, or in the case of the aggressive individuals, punishment by the local authorities, which had not prevented them from being chronically in trouble. In
Jilek's view, moreover, the renewed institution of the guardian spirit ceremonials
is helpful not only to specific troubled individuals, but to the community as a
whole, which is recovering its Indian identity.

Howard Stein (1977), in his review of Jilek's book, again raises the question:
what do we mean by "cure"? He wonders whether by joining this cult, the
patients do not simply substitute one form of "addiction" (the cult) for an older
one, such as alcoholism or drugs. Also, he asks whether it is useful for these
people to reaffirm an Indian identity, instead of seeking to make their way in the
"real" world of white industrial Canadian society. The difference between this
situation and, for example, that of the Bori cult members among the Hausa, seems
to be that the Indians seek to reconstruct the old ways, when they actually may
have an alternative. The Hausa simply continue, for the time being, to live in their
traditional society.

The problem is an interesting and difficult one, and it has many practical
implications. In some ways, the case of the Salish Indian cultural revival and the
psychotherapeutic identity changes it brings about in individuals is reminiscent
of the great religious ferment that has been in existence in the United States for
a number of years. This ferment has involved a variety of Eastern religions, as
well as vigorous pentecostal and charismatic movements within and outside of
a great many Christian churches. There have been numerous reports claiming
that such religious conversions have brought about personal transformations,
including the rehabilitation of drug addicts and alcoholics. The questions raised
by Stein are similar to those brought up by Prince with regard to the need for
patients to gain insight into their underlying unconscious emotional conflicts.

Some Practical Applications

Because Western-trained psychiatrists have discovered at various times and in
various places that they have not been successful among culturally different,
traditional, populations, and also perhaps because they are few in numbers,
several have undertaken striking and bold experiments. The first Nigerian psychiatrist,
T. A. Lambo (1964), began to experiment in 1954 with village-based
community psychiatry. This experiment included cooperation among the psychiatrist,
the hospital staff, and traditional healers or "witch doctors," an idea that was
shocking to most Western physicians.

Both the community-based treatment facility and the collaboration with folk
healers have since gained widespread acceptance in many parts of the world. In
Dakar, Senegal, such cooperation has been developed by French and French-
trained African physicians and folk healers among several local ethnic groups. In
the United States, Cornell University has established a project among the Navajo
Indians incorporating many of the features of Lambo's work.4 Harwood (1977),
Garrison (1977), and Koss (n.d.) are anthropologists who have worked with
Puerto Rican spiritists either in Puerto Rico or in New York City, while they were
associated with community health projects. In these and in many other cases
around the world, anthropologists have worked as cultural interpreters; they have
studied the local social system and the local beliefs and practices concerning
disease and healing, and have assisted psychiatrists in understanding the behav­
ioral world of their patients. On the other hand, in many instances they have also
explained the world of the psychiatrists to the folk healers and to the local
community. This work is now a major activity for those involved in the growing
field of medical anthropology.

As we have seen, cultural factors must be taken into consideration in seeking
to understand mental disorders, and in the types of treatments to which members
of different societies are likely to respond. When the therapist and the patient
belong to the same society and share the same view of the forces that shape health
and illness, the therapeutic process is furthered, when they approach the problem
with different perceptions and different interpretations, the therapeutic process is
complicated by this fact. This difficulty is increasingly being recognized in many
developing areas of the world, and perhaps, to a lesser extent, in the United States.
Here, too, there are many ethnic groups with their own systems of religious
healing, and it is possible that their efforts might be mobilized for cooperation
with mental health specialists. As Allan Harwood (1977) notes, in concluding his
book on Puerto Rican spiritists in New York:

In this period of United States history, when many of the values and norms of the
society are being called into question and a more relativistic ethical system is appar­
tently emerging, it seems appropriate for those in the helping professions to reevaluate
their premises and techniques. . . . Many workers are increasingly open to new forms
of treatment and to view people in their socio-cultural context before instituting

Under these circumstances, an anthropological understanding of sociocultural
systems clearly seems to have practical applications.

SUMMARY

In this chapter we have considered a number of related questions concerning the
area of overlap between psychological anthropology and psychiatry. As so often
before in this book, we have been faced both by evidence of universal human
characteristics and by the importance of cultural differences and variability.

We noted at the outset that major psychiatric disorders, such as schizophrenia,
appear to exist in all human societies, that they exhibit the same basic features,
and that they are recognized as disorders by people everywhere. However, there
are important differences in the ways in which these disorders are explained and
in which patients are treated, not only differences between traditional and modern
societies, or among traditional societies, but even differences between modern
industrial societies. For example, J. M. Townsend (1975) studied matched sam­
pies of one hundred mental patients in a U.S. and a German psychiatric hospital.
He found statistically significant differences between these two samples of patients in how they viewed themselves and their illness. Whereas the German patients thought of mental illness as biologically caused and generally incurable, U.S. patients held that they were themselves partially responsible for their own conditions and that they could therefore improve, given proper motivation and help. The author points out that this notion of "behavioral free will"—the idea that one can shape one's own destiny—has been noted by many observers as a major theme of U.S. ideology. The concept of mental illness as a deviation, and its treatment through spirit possession rituals, also shows how Oscar, in his madness, highlights the inherent in the value system of his society by violating its rules, especially the rules concerning privacy.

Next, we again saw how the cross-cultural approach allows us to test hypotheses derived from a single culture; specifically, societies of a different type allow us to discover unexpected implications of hypotheses derived from conditions in modern Western societies. We had earlier considered this issue in connection with Margaret Mead's study of adolescents, and we now consider it in reference to stress and crowding.

Pushing the issue of cultural variability a step further, we reviewed discussions about the possibility that there might be mental disorders that are unique or specific to certain cultures. This question led us to yet another problem, the relative merits of emic and etic approaches to mental illness.

Since mental illness occurs universally, most, if not all, societies have developed healing systems, and research has shown that at least some of them are effective. Their success presents a challenge to Western medicine. To account for it, often observers have compared traditional and Western systems, producing a double-barreled conclusion: effective traditional methods are found to contain many features that seem to make them similar to modern medicine. Are native healers therefore really psychiatrists who differ from their modern counterparts only in their jargon? Or are modern psychiatrists really witch doctors who use magical means in curing their patients, regardless of whether they are aware of doing so?

This discussion finally has led us to consider the possible practical applications of the knowledge anthropologists have acquired concerning traditional societies and their healing systems. Under certain circumstances, the anthropologist may act as an interpreter of traditional ways to the psychiatrist and of the psychiatrist's ways to the people. In a number of places, in recent years, traditional healing methods have been used in collaboration with modern medicine, and such cooperation has appeared to produce better results than have been obtained when the two systems have worked as competing or mutually hostile institutions.

NOTES

1. In April 1978 a German court convicted two Catholic priests and the parents of a young woman, Anneliese Michel, of having contributed to her death. According to medical testimony, the patient had suffered from epilepsy and had died of starvation. The priests had carried out a prolonged series of exorcistic rituals, "driving out" a great number of evil spirits, Adolf Hitler among them. These demons, they believed, were causing the girl's illness by possessing her. The patient died before she attempted to live only on holy water for a time, refusing all food.

2. In his great novel, Remembrance of Things Past (1932–1934), Marcel Proust, in a famous passage, describes how his narrator gropingly rediscovers forgotten memories, when vague hints of recollections are stirred up in his mind by the eating of a fine pastry, called a madeleine, which he had not tasted in a long time. Ernest Schachtel (1959) in a justly famous paper entitled "On Memory and Childhood Amnesia" discusses this case and some other examples in detail.

3. Were Ni (He Is a Madman): The Management of Psychiatric Disorders by the Yoruba of Nigeria, Raymond Prince and Frank Speed. This excellent film is available from Professor Prince through the R. M. Bucke Memorial Society for Religious Experience, in Montreal, Canada.

4. Prince (1979b) discusses the relationship between the psychiatrist and the folk healer as a partnership. In this article he notes the fact that in 1977, the World Health Organization, in an editorial in its journal World Health, was advocating cooperation between physicians and health personnel and native specialists, including herbalists and midwives. Prince shows how this attitude represents a drastic reversal of a long-standing position of Western specialists, who saw in folk healers only ignorance compounded by charlatanism.