Culture

Culture and Psychopathology Revisited

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Article abstract

The author presents examples of pathogenic influence of culture. He identifies specific pathogenic factors associated with rapid socio-cultural change affecting North American Indians and African populations and sketches the resulting typical psychopathological conditions: anomic depression in Amerindians, transient psychotic reactions (bouffée délirante) in Africans. Witchcraft and sorcery beliefs often characterize the clinical picture of psychotic reactions in "marginal" Africans and in transplanted South Europeans of tradition-directed background. Examples are provided which illustrate the emergence, metamorphosis and epidemic spreading of so-called "culture-bound syndromes" under changing socio-economic, cultural and political conditions. Ritualized possession and trance states, as well as religious rituals in general, are to be separated from psychopathological phenomena in order to avoid eurocentric and positivistic fallacies in psychiatric diagnosis.

Culture and Psychopathology Revisited

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The author presents examples of pathogenic influence of culture. He identifies specific pathogenic factors associated with rapid socio-cultural change affecting North American Indians and African populations and sketches the resulting typical psychopathological conditions : anomic depression in Amerindians, transient psychotic reactions (bouffée délirante) in Africans. Witchcraft and sorcery beliefs often characterize the clinical picture of psychotic reactions in "marginal" Africans and in transplanted South Europeans of tradition-directed background. Examples are provided which illustrate the emergence, metamorphosis and epidemic spreading of so-called "culture-bound syndromes" under changing socio-economic, cultural and political conditions. Ritualized possession and trance states, as well as religious rituals in general, are to be separated from psychopathological phenomena in order to avoid eurocentric and positivistic fallacies in psychiatric diagnosis.

L'auteur donne ici des exemples d'influences pathogéniques de la culture et identifie des facteurs pathogéniques spécifiques qui se trouvent associés à des changements socio-culturels rapides parmi des populations africaines et amérindiennes (Amérique du nord). Est présentée une esquisse d'états psychopathologiques typiques : dépression anomique chez les Amérindiens, bouffées délirantes chez les Africains. Des croyances à des pratiques de magie et de sorcellerie caractérisent souvent les réactions psychotiques d'Africains marginalisés et d'Européens originaires de milieux traditionnels du sud de l'Europe transplantés dans d'autres situations culturelles. Sont ainsi cités des cas d'émergence, de métamorphose et de diffusion massive de syndromes induits culturellement dans des contextes de changement socio-économique, politique et culturel. Il est en effet nécessaire d'établir une différenciation entre des états de possession et de transe rituelles, et tout rituel religieux en général, et les phénomènes psychopathologiques afin d'éviter la formulation d'interprétations eurocentriques et positivistes lors de l'élaboration d'un diagnostic psychiatrique.

The system of behavioral, attitudinal and conceptual norms differs from culture to culture, and it is these differences that cross-cultural comparison of "normal" and "abnormal" states of mind has to take into account. Beguin's (1952) dictum "on est fou par rapport à une société donnée", expresses a radical view of cultural relativism in psychopathology which appears to deny the existence of universal standards. There are, however, mental conditions the abnormal character of which is recognized across cultures, such as idiocy, dementia, agitated

delirium, all that was called "total insanity" in ancient psychiatry (Ellenberger, 1960). Nevertheless there can be little doubt that in the great majority of psychiatric conditions culture plays an important rôle. The question is, whether that rôle is *pathogenic*, i.e. causing pathology, or *pathoplastic*, i.e. shaping pathology ; a question which has to be considered for each clinical manifestation. The prevailing view in comparative psychiatry has always been that cultural factors have pathoplastic rather than pathogenic effects. It may be of interest therefore, to mention from our own experience some examples of unequivocally *pathogenic* influence of culture.

(1) Culturally prescribed patterns of breeding may enhance the risk of neuropsychiatric illness by disadvantageous gene distribution. Among the Wapogoro of Tanzania, we found a culturally preferred pattern of mating between cross-cousins and between members of epileptic families, and this mating pattern appeared responsible for the high prevalence (2%) and family incidence of a seizure disorder often associated with psychopathology. (Jilek-Aall, Jilek and Miller, 1979).

(2) Culturally prescribed obstetric practices may lead to brain damage with neuropsychiatric symptoms, as among tribal populations in East Africa. (Jilek-Aall, 1964).

(3) Culturally or subculturally sanctioned use and abuse of noxious substances such as alcohol, narcotics and psychedelics, exert both pathogenic and pathoplastic effects. Culturally sanctioned abstinence from such substance use, as e.g. among the active participants of the revived Salish Indian spirit dance ceremonial, is the main factor in the prevention of alcohol—and drug—associated mental conditions. Cultural sanctions against solitary drinking accounts for the low incidence of chronic alcoholism in Chinese society (Tseng and Hsu, 1969).

Cultural factors inherent in modern Western society have been held responsible for schizophrenia by Devereux and his school of psychoanalytic ethnopsychiatry. In a recent work Devereux (1980) repeats his view of schizophrenia as an "ethnic psychosis" characteristic of modern Western society. He sees schizophrenic thinking and behaviour as "taught" and "inculcated" by modern civilization. Devereux's claim that "true" (process) schizophrenia has never been encountered in primitive populations not yet subjected to westernizing acculturation has been refuted by field observations of experienced clinicians ; so among Australian aborigines by Cawte (1965), and among isolated tribal populations in East Africa by Jilek-Aall (1964). However, chronic process schizophrenia appears to be less prevalent in tradition-directed societies without westernizing culture change (Rin and Tsung-Yi Lin, 1962 — aboriginal Formosans ; Burton-Bradley, 1975 — primitive villagers in Papua New Guinea). It is also hardly conceivable that schizophrenia should be a product of modern society if we find descriptions of schizophrenic conditions in early medical texts. The oldest documentation of a paranoid schizophrenia-like disease then known as "excited insanity" goes back about four thousand years to the ancient Chinese medical classics *Nei Ching* and *Nan Ching*, as Tseng (1973) has shown.

Socio-cultural factors exert their influence mainly on the symptoms and on the course of schizophrenia. The results of several cross-cultural inquiries point to a considerable variation in the frequency of certain types of hallucinations and delusions, of catatonic symptoms and affective responses according to culture area, predominant religion, degree of urbanization and industrialization (Wittkower, Murphy, Fried and Ellenberger, 1960 ; Murphy, Wittkower, Fried and Ellenberger, 1963 ; Pfeiffer, 1971 ; Rogan, Dunham and Sullivan, 1973).

Clinicians working among tribal populations of development countries have for a long time reported observations indicating that the longterm prognosis of schizophrenic psychoses is overall better than in the Western industrialized world, and that there is less tendency of progressing in chronic courses toward deterioration. These clinical impressions have since been confirmed for the indigenous population of Mauritius by Murphy and Raman (1971) who in their twelve year follow-up study of mental hospital patients found that schizophrenic psychoses ran a less chronic course in Africans and Asians than in Europeans. On a global scale, the international follow-up study of schizophrenia conducted by the World Health Organization (1979) found that in the developing countries significantly more of the schizophrenia probands improved than in the developed countries. There is as yet no conclusive explanation for these epidemiological findings. On the basis of our experience with transient psychoses in Africa we suggested in 1970, that a chronic course might be averted if the community responds to the initial psychotic episode by sympathetic acceptance, benevolently protective attention and assistance in a culturally prescribed way, as is the case in many tradition-directed small scale societies. Conversely, Western societies have

developed response patterns vis-à-vis the phenomena of acute psychosis which consist of the patient's covert or over rejection by those around him, leading to his social isolation and stigmatization, and to the expectation that he remains in an incompetent sick rôle. It is these response patterns that appear to favour chronicity.

In his recent treatise, Murphy (1982) analyses precipitating-aggravating *vs* protecting-relieving factors affecting the course and outcome of schizophrenic psychoses : strict or contradictory *vs* liberal and modest social expectations ; absence or complexity *vs* simplicity and completeness of social rules. He also demonstrates the historical transformation of the predominantly somatic syndrome of medieval melancholia into the predominantly psychic syndrome of depression under the influence of ideological and socio-economic forces in 17th-18th century Europe, a process currently under way in many development countries.

Of great relevance among the socio-cultural factors impinging on mental health are *culture change* situations which have been found to generate psychopathology specifically in the case of imposed rapid Westernization of small scale non-Western societies (Murphy, 1961). I have in previous studies (Jilek, 1982) tried to determine the significant pathogenic factors which are operant in rapid socio-cultural change situations affecting North American Indians. In this instance pathogenic effects derived from :

(1) *anomie* (Durkheim, 1897), the loss of norms which guide individual conduct ;
(2) *relative deprivation* (Aberle, 1966), defined as a negative discrepancy between expectations and actuality in terms of socio-economic and legal-political status ;
(3) *cultural confusion* (Leighton et al, 1963). Cultural confusion ensues when in close contact with a technologically superior culture, indigenous people are confronted with contrasting and contradictory values and are unable to integrate the two different sets of norms.

These factors are operant in the development of the syndrome I have called *anomic depression*. It is frequently encountered in North American Indians under conditions of rapid culture change. Among the Salish Indians of the Pacific Northwest the traditional native concept of *syewen* spirit illness, formerly a ritualized seasonal state of prescribed extracurricular behaviour which preceded initiation to spirit dancing, has in recent times been redefined by the tribal elders to fit the chronic neurotic-depressive symptom formation associated with a typical pattern of alcohol abuse and suicidal or aggressive actions. By accepting the label *syewen* spirit illness and manifesting its culturally stereotyped signs at the appropriate time, a young Salish Indian suffering from chronic anomic depression becomes a candidate for the revived spirit dance initiation. The initiation process equals an indigenous therapy which in our experience is more likely to lead to full rehabilitation than any Western treatment modality.

In Africa socio-cultural change under Westernizing[1] influences is characterized by rapid transformation of tradition directed tribal societies into semi-urbanized mass societies of modern Western type. Psychosocial concomitants of this transformation are *anomie* and cultural identity confusion. These are generated by

(1) the impersonalization of social relationships,
(2) ambivalence conflicts when imported Western values, regarded as alien and linked to a colonial past, are at the same time aspired to while the venerated traditional norms are no longer accepted as universal guiding principles ;
(3) the widening gap between the now "legitimized" individual aspirations and the impossibility for the masses ever to reach these widely emphasized goals.

This process of rapid culture change is reflected in an increase of psychopathological states which in Africa, today as in the past, are often attributed to witchcraft or sorcery. It is therefore not surprising that a review of available reports from sub-Saharan Africa revealed a trend toward re-activation and intensification of magic beliefs and practices, including antiwitchcraft movements (Jilek, 1967). The most typical clinical condition encountered in this context is the transient psychotic or psychosis-like reaction labelled *bouffée délirante* in francophone psychiatry. Collomb (1956 ; 1965b) and his colleagues in West Africa considered this to be the characteristic syndrome of contemporary African psychiatry. They described *bouffée délirante* as transient reactive psychotic state, with intense anxiety, confusional elements, floating paranoid delusions, also frequently hallucinations ; or sudden onset and of brief duration ; ending with spontaneous and complete remission, followed by systematic disavowal of the often embarassing and dangerous behaviour. Identical conditions have been recorded in anglophone Africa under diagnoses such as transient psychotic confusional state, primitive confusional psychosis, acute paranoid state, fear psychosis, reactive psychosis (Jilek and Jilek-Aall, 1970).

Paradigmatic are Lambo's (1956, 1960, 1962) descriptions of conditions for which he used the terms *malignant anxiety* and *frenzied anxiety* : acute anxiety reactions resembling hysterical panic states,

with paranoid features centered on delusions of bewitchment. *Frenzied anxiety* was equated by Lambo (1960) with the *bouffée délirante* of his francophone colleagues in West Africa. An identical condition has been reported by Burton-Bradley (1975) as "New Guinea transitory delusional state".

Associated with these transient reactive psychoses is the danger of aggressive discharges and violent acts, well documented in African forensic psychiatry. It is of interest that the term *frenzied anxiety* was originally introduced in Kenya by Carothers (1947) for acute brief psychotic reactions with aggressive, often homicidal behaviour similar to the *amok* syndrome of Malaysian cultures but unlike the latter usually precipitated by fears of bewitchment.

Many possible organic conditions have been considered as underlying causes of transient psychotic reactions in tropical areas (cf. list in Jilek and Jilek-Aall, 1970), but have rarely been demonstrated in the examined cases. This prompted Lambo (1965) to emphasize the role of socio-cultural factors in a summarizing statement : "These reactions would seem to be much more related to culture than to infection." At risk are the "marginal" Africans, the detribalized, semi-Westernized new townspeople, among whom morbid fear of bewitchment is prevalent and who are "in the process of renouncing, or have unsuccessfully renounced, their age-old culture but have failed to assimilate the new" (Lambo, 1962).

In these reactive psychotic states, anxiety becomes truly malignant if the patient's delusion of being a victim of inescapable magic retaliation, is shared by his own people. There is a high risk of lethal outcome if such is anticipated by the afflicted as well as by his group, and reinforced by collective suggestion. An extreme example of socio-cultural pathogenesis is then provided by the phenomenon of "voodoo death", variously labelled *thanatomania* (Ackerknecht, 1943) ; psychogenic death (Ellenberger, 1951) ; *mort psychosomatique* (Collomb, 1965a). "Voodoo death" was attributed by the famous physiologist Cannon (1942) to irreversible shock through overstimulation of the sympathico-adrenergic system, induced by intense emotional stress and dehydration[2]. Richter (1957) concluded from his animal experiments that "voodoo death" results from hyperactivity of the parasympathetic nervous system in a situation of hopelessness, a hypothesis reflected in the German term *Vagus-Tod* (Bilz, 1966). In her book on medical experiences in East Africa Jilek-Aall (1979, chapter II) reports the case of a healthy young man who died because everybody expected him to die from a blood sucking spirit as he had violated a sacred taboo by trying to seduce a secluded virgin, whereupon he was "cursed to death" by the girl's father.

The emergence, metamorphosis, epidemiological prominence and eventual decline, of "culture bound syndromes" under the effects of societal and cultural change has been demonstrated for *amok* and *latah*. Teoh (1972) showed how under negative societal sanctions *amok* evolved from a deliberately induced, conscious form of revenge seeking suicidal behaviour, tolerated in Muslim Malayan societies, to an unconsciously motivated psychiatric syndrome of diverse aetiology. In his detailed historical study, Murphy (1973) documented the decline in incidence of *amok* in centers exposed to European colonial influence from the mid-19th century onwards, with a marked shift from consciously motivated behaviour to an unconscious dissociative reaction in otherwise normal individuals, and a further shift to episodic occurrence in the course of mental illness. Murphy (1973) also documented the first appearance of *latah* during the second half of the 19th century at a time of consolidation of the European colonial system. According to Murphy's data, *latah* spread rapidly among those indigenous populations which were under direct European influence ; it subsequently moved away from these centers to more distant areas where it is found today. The previously observed male form has almost disappeared, the intensity of attacks has decreased, and the residual subjects appear less intelligent than the earlier ones. Murphy (1973) concluded that the syndromes of *amok* and *latah* "are best conceived not as offshoots from Malaysian cultural tradition but as the transitional products of an interaction between that tradition and certain modernizing influences". Kenny (1978) in a recent analysis of ethnographic data showed that classical examples of *latah* behaviour follow a cultural pattern which is deeply rooted in the metaphysical concepts of Malayo-Indonesian culture. However, his position that *latah* is unique to that culture has been eroded by Simons' (1980) documented reports and recordings of *latah*-like behaviour in *hyperstartling* persons from genetically and culturally unrelated populations (e.g. also among French North Americans, Beard, 1880). In Simons' view, the various forms of *latah* are culture-specific exploitations of a neurophysiological potential demonstrably present in mammals. In other words, what is unique is the specific pathoplastic effect of a given culture — always subject to change — and what is universal is the underlying neurophysiological potential of certain individuals to exhibit hyperstartling reactions.

Under conditions of acute socio-cultural and politico-economic stress which affects not only an individual but his entire group, "culture bound syndromes" which usually occur in isolated cases, may assume epidemic proportions, especially in times of international or inter-racial tension.

Czaplicka (1914) reported an episode during the Russo-Japanese war in which *miryachit*, the Siberian equivalent of *latah*, was collectively manifested by a military unit :

> Once, during a parade of the 3rd Battalion of the Trans-Baikal Cossacks, a regiment composed entirely of natives, the soldiers began to repeat the words of command. The colonel grew angry and swore volubly at the men ; but the more he swore, the livelier was the chorus of soldiers repeating his curses after him.

In 1976 we were able to observe the unfolding of a *koro* epidemic in Thailand among rural Thai people in whom this supposedly Southern Chinese syndrome had been practically unknown. There were rumours and media reports of sensational food poisonings allegedly perpetrated by the Vietnamese in a sinister plot to sabotage health and sex life of the Thai nation. The epidemic appears to have originated among students of a Technical College in the northeastern border region who proceeded to pogrom-style retaliations against the Vietnamese ethnic minority. Within a few days about two hundred persons reported for treatment at the local hospitals of the border areas in panic states with mysterious symptoms affecting sexual and vital functions. Most of the patients were Thai peasants without knowledge of the concepts of classical Chinese medicine. Two thirds were men, among them one Buddhist monk. The complaints were stereotyped : shrinking of the penis and sexual impotence in men, shrinkage or itching of the external genitals and frigidity in women ; associated symptoms were nausea, dizziness, abdominal pains, numbness, headaches. All sufferers were beset by fear of imminent death, some fainted on arrival in the hospital. After brief symptomatic treatment, or without any treatment, all patients recovered. Nevertheless, there was widespread belief that Vietnamese agents had contaminated food stuffs, beverages and tobacco. The health authorities ordered an investigation and it was later announced that careful analysis of the accused items had detected no foreign substance that could possibly cause the reported symptoms. However, security officials were quoted in newspapers as stating that the harmful matter was a "mixture of some vegetable ingredients which could not be detected by medical devices" (*Siam Rath*, Nov. 18, 1976) and police were reported to "watch out for some Vietnamese residents who might try to put more of the allegedly poisonous powder in noodles or cigarettes" (*Dao Siam*, Nov. 15, 1976).

It may be said that no true understanding of the pathogenesis of this mass hysteria with *koro* symptoms is possible on the basis of a culture-specific model referring to the pathoplastic influence of Taoist doctrines (*yin-yang* imbalance) ; or on the basis of a psychoanalytic model (oedipal conflicts, etc.), which have both been promulgated in explanations of *koro*. Rather, such understanding requires due consideration of the socio-cultural and politico-economical conditions of Southeast Asia, and their impinging on the individual's psychological and experiential make-up. The phenomenon of this *koro* epidemic can therefore stand as a paradigm of collective socio-cultural pathogenesis.

Transient psychotic and psychosis-like states of "culture bound syndrome" type are by no means the prerogative of non-European peoples. Throughout European history psychotic reactions in the context of magic beliefs were frequently recorded (Friedreich, 1830). Paroxysmal behaviour closely resembling *amok* in Malaysians and malignant or frenzied anxiety in Africans, was exhibited in the berserker attacks (*berserksgangr*, Norse) of early mediaeval Scandinavia as documented by the research of Weiser-Aall (1927). The lycanthropic *werewolf* delusion of transforming into a wild beast craving for human flesh and blood was common in mediaeval Europe. In many aspects analogous to the Algonkian Indian *witiko* psychosis, this werewolf psychosis led to very similar social consequences. Under conditions of radical culture change in the transition from pagan Nordic to Judaeo-Roman-Christian civilization, *berserkers* and *werewolves* increased in number and destructiveness, some times to epidemic proportions (Laiblin, 1965).

Until the mid-19th century, a transient hallucinatory excitement state with hysteriform attacks and delusions of daemoniac possession, called *Daemono-Melancholie*, was a frequently encountered clinical condition in Central Europe, according to Griesinger (1867) the pioneer of German scientific psychiatry. Acute psychotic reactions of brief duration and favourable outcome, precipitated by intense fear of witchcraft or sorcery, are not at all rare in contemporary Europe. Jacquel and Morel (1965) reported on delusions of bewitchment (*délire de sorcellerie*) in Northwestern France. In Switzerland, Risso and Böker (1964) investigated South Italian "guest workers" who had been hospitalized with symptoms of frenzied excitement, fear of imminent death, floating hallucinations and para-

noid behaviour, all in the context of delusions of bewitchment and sorcery (*fattura*). Experiencing a culture shock when exposed to a foreign milieu with alien norms of conduct, especially in the area of interpersonal relations between the sexes, these migrant workers developed paranoid psychotic states. There was a tendency to (mis)diagnose these cases as schizophrenia, although they responded well to suggestive assurance and brief sedation with speedy recovery and without any chronicity or residual defects. The authors felt that in the framework of Swiss diagnostic nomenclature, these cases would fit well into the category "schizophrenia-like emotional psychosis" (Labhardt, 1963); defined as transient and brief psychotic reaction of acute schizophrenic type; precipitated by severe emotional stress, often in the context of a "magic-archaic" world view, and responding well to milieu and psychotherapeutic measures.

We at once recognize the close relationship of this Swiss diagnostic entity with the *bouffée délirante* of French authors. French psychiatry, by maintaining the latter diagnosis independent of the concepts of schizophrenia and hysteria, is avoiding much of the controversy surrounding the classification of acute transient psychotic reactions in general, and of culture bound syndromes in particular.

Ritualized possession and trance states must be separated from culture bound reactive syndromes. The former are culturally sanctioned states, institutionalized in many societies and induced for a — usually religious or therapeutic — purpose. The latter, while culturally recognized and explained, are defined as abnormal by the indigenous experts. When attempting to classify unusual behaviour in another culture according to psychiatric nomenclature, one has to inquire with the informed and discerning members of that culture whether such behaviour is culturally defined as normal or pathological in the given situational context. In Ackerknecht's (1943 ; 1971) terminology, one has to find out whether such behaviour is *autonormal* or *autopathological*. In attaching pathology labels to behaviour which in the subject's own non-Western culture is considered normal in a particular context, the Western trained psychiatrist may commit a *eurocentric fallacy* by ignoring the foreign culture's behavioural norms and its folk system of explanation. The pathology labelling of ritualized possession and trance states constitutes also a *positivistic fallacy* insofar as it considers behaviour psychiatrically abnormal because it does not fit into the framework of the logico-experimental explanatory theories of positive science. Ritualized possession and trance states, and also shamanic and religious ceremonials, cannot be judged by the criteria of positive science, for ritual acts are, above all, "manifestations of sentiments" as Pareto (1935) has shown. Ritual acts are either methodologically *a*logical as in magic and shamanism, or ultimately *a*logical, as in religion (Levy, 1948). At no time should culturally sanctioned ritual practices be interpreted as *il*logical or *ir*rational thinking and as evidence of mental illness.

NOTES

1. My term "Westernization" denotes overriding modernistic influences of European, American or Soviet provenance, as both Liberalism and Marxism are of Western European origin and remain fundamentally alien to the socio-cultural and religious-philosophical traditions of Third World cultures.

2. In arid tropical climates, absence of fluid intake may lead to death by dehydration in 24 hours. Fluid intake may be refused by a prospective victim of "voodoo death", under the impact of collective suggestion that death is inescapable. Eastwell's (1982) observation on death by dehydration through ritual withholding of fluids from persons dying or presumed to die, is not "voodoo death", but *emic* euthanasia practised by East Arnhem aborigines. It has not been reported outside Australia.

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