CHAPTER TWO

Theoretical Considerations
CHAPTER II
THEORETICAL CONSIDERATIONS

A BRIEF OVERVIEW

Mental illness is more or less an unexplored field in India, particularly from the social-psychiatric point of view. It is normally considered a problem which is technically enigmatic and socially stupendous.

From the time of conception, individuals are exposed not only to a physical and chemical environment, and variations in climate, nutrition, and somatic health, but also to a series of social, psychological, and cultural phenomena that influence and enrich the process of learning which determine, to a large extent, the individual experience, character and responses.

Mental disorder exists in all societies, but the guises in which it presents itself may vary. Even more variable are the concepts which, in different societies and at different times, characterize mental illness and the way in which the mentally ill are treated.

In Biblical times and even in many parts of India today, the mentally ill are thought to be possessed of unclean evil spirits, or the devil. In colonial days there are reports of them being burned as witches, but in some societies they have been regarded as soothsayers. In Medieval Europe they suspended a mad man just above a pit
full of snakes. They thought that the shock and the terror would bring him to his senses. The researcher observed that in many parts of rural Maharashtra, India, a red hot iron rod was placed on the temples of the mentally ill. It was believed that the intense heat and pain would not only chase the evil spirit from his body but would also shock the victim out of his madness. (Other traditional methods of cure have been reported in Chapter V).

In spite of our knowledge of the workings of the human mind, in India, we have not really advanced very much in our methods of curing mental disorders. Instead of the snakes and heated iron rods, we use electricity, insulin and tranquillizers. In his study, the researcher observed many mental patients who suffered from deep guilt neurosis and looked upon electroconvulsive therapy as a kind of deserved punishment. After undergoing this "punishment" of electric shocks for whatever crime they thought they were guilty of, they felt as though they had done penance for it and thus, many symptoms relating to the guilt neurosis eased off.

Mental disorder is primarily manifested in behaviour. It may be associated with a variety of physical symptoms or with no physical symptoms whatsoever.

Thomas S. Szasz (1962) has argued that the model of organic mental ailment is a false analogy. Sharing this view, Thomas J. Scheff (1966) has argued that the
application of a diagnostic label to a patient, who may be in a confused suggestible state, may reinforce his acceptance of the role of a mentally ill patient. From the viewpoint of a traditional psychiatrist, diagnosis is the first step leading to a cure. From Scheff's point of view, diagnosis may confirm the patient in his "Abnormality."

In support of the "no sickness" model is the fact that many cases of mental disorder seem to have no organic impairment; they are "functional," psychogenic in origin. But not all psychiatrists or psychologists would agree to that. Bernard Rimland (1969) for one, believes that most mental disorders probably do have an organic basis, but our present limited knowledge does not allow us to identify the organic defects in many cases.

Etiological theories of psychiatric disorder, whether they are biological or psychological, have generally focused on something that is going on within the patient. Most of these theories have not concerned themselves with external sociological or environmental stress, as a factor producing psychiatric disorder. For instance, the studies of Slater (1951), Kallmann (1959), Essen-Moller (1941), Kurian, et al. (1978) and others have shown the importance of hereditary factors in the etiology of schizophrenia.

Sociological theorists tend to view psychiatric illness as one form of social deviation, thereby placing their stress on the phenomenon of social labelling. In this
model, the patient is regarded as mentally ill primarily because he has broken the local code of social conduct or norms. Implicit here is a conception of psychiatric disorders as motivated acts of norm-breaking, rather than as products of underlying biological reactions, which remain outside the individual's control.

The feature that is unique to human beings, by contrast with members of the animal world, is that they live in social groups, whose activities, sentiments and interactions are to a great extent determined by cultural patterns handed down from generation to generation. Like tuberculosis, psychiatric illness is multifactorially determined. Unlike the tubercle bacillus, however, which is a necessary but not a sufficient cause of tuberculosis, cultural factors are not necessary to mental disorder, but they may be sufficient causes of it, (Kiev, 1972:14).

In his paper on "Culture and Mental Illness," Ashley Montagu (1961) said: "It should be understood that with the development of human culture man has entered a new zone of adaptation, in which, through the socialization process, he learns what is expected of him and what he may expect from others. He internalizes the norms and acquires a working knowledge of his culture as a whole. While no one in any culture ever develops a mastery of every aspect of the culture, in different cultures and in different segments of the same culture there exist significant differences
in both the quantity and the complexity or quality of the cultural variables, a good many of which the average member of such a culture is able to command. In general, nonliterate cultures are both quantitatively and qualitatively less demanding of their members than literate cultures, at least this would appear to be so. The individual is simply not assaulted by so many and so various stimuli or expected to know and do as much as the average member of literate cultures."

Opler (1959) supplants the above statement by saying, "culture is, in part, a symbolic organization of behaviour in which the meaning of that behaviour is expressed in interpersonal processes stemming from cultural traditions."

Cultural factors interact with a number of variables in the development and natural history of psychiatric disorders. They may, for example, perpetuate the environmental conditions for the breeding of infectious agents, or they may contribute to the reduction of resistance in the human host.

Culture determines the specific ways in which individuals perceive and conceive of the environment and strongly influence the form of conflict, behaviour and psychopathology that occur in members of the culture, (Kiev, 1972). A study of the cultural milieu provides an opportunity to extend the clinical picture of psychiatric condition
with special emphasis on the relationship between environmental factors and psychiatric disorders.

Growing anthropological interest in the fields of ethnomedicine, ethnopsychiatry, ethnosophiology, and "anthropo­

therapy" (Brameld 1965) has made applied anthropologists more aware of the manifold aspects and consequences of their practices.

In his authoritative and well documented paper, "Concepts and a Model for the Comparison of Medical Systems as Cultural Systems", Arthur Kleinman (1978) says: "... a model of medicine as a cultural system will be valuable if it can (1) operationalize the concept of culture in the health domain in more precise and potentially quantifiable ways; (2) relate directly to clinical questions; (3) specify hypotheses which could be falsified against existing data or confirmed in prospective field studies; (4) provide systematic interdisciplinary translation between anthropology and the health sciences; and (5) provide a terminology that is not limited to biomedicine, but through which biomedicine can be related to other professional, as well as popular and folk, healing traditions within a broader comparative cross-cultural science of sickness and health care."

Dubreuil and Wittkower (1976) has said that: "intimate knowledge of human groups will help to promote positive changes in families, communities, and societies
at large, and that these changes will lead to a decrease in mental illness, delinquency, criminality, and violence. Evolution toward a "better society" continues to be the basic assumption and goal.

Most anthropologists, at least until very recently, have emphasized the positive factors of culture. They have noted positive social and psychological functions for many phenomena that psychiatrists would consider pathological, including trance and possession (Herskovits 1937; Lee 1968 and others), witchcraft (Evans Pritchard 1937; Fortune 1932), and aggression (Chagnon 1968). This somewhat unilateral conception of culture is now changing. Research in acculturation, in culture and personality, and in psychiatric anthropology has led many anthropologists to insist that some negative aspects of culture and especially of culture contacts exist.

The well-known anthropologist Margaret Mead (1953) has shown vividly how even physiological functioning and physical development are shaped by sociocultural factors. She makes it clear that culture is seen not as a set of external impacts and catastrophes to which an organism... is subjected, but as a principal element in the development of the individual, which will result in his having a structure, a type of functioning, and a pattern of irritability different in kind from that of individuals who have been socialized with another culture. The functioning of
every part of the human body is moulded by the culture within which the individual has been reared—not only in terms of diet, sunlight, exposure to contagious and infectious diseases, overstrain, occupational disease hazards, catastrophics and traumatic experiences, but also by the way that he, born into a society with a definite culture, has been fed and disciplined, fondled and put to sleep, punished and rewarded.

In the light of this holistic approach every socialized individual is seen as so profoundly moulded by his culture that the most fundamental life processes will have systematically different patterns even though these patterns may all lie within the margin of safety for human functioning.

In addition to biological changes induced by the cultural setting, anthropological studies have shown that varying patterns of social organization seem to breed somewhat different types of mental disorders. In some societies trends in mental illness have been found which are considerably different from what is observed in another society, apparently reflecting differences in sociocultural conditions rather than biological differences. Even within a society investigators have found differences between rural and urban areas and between different socioeconomic levels.
CROSS-CULTURAL STUDIES ON MENTAL DISORDERS

The antiquity of mental disorders dates back to the hoary millennia. The Bhagavad Gita talks of the mental depression of Arjun. The earliest writings in Egyptian, Greek, Hebrew and Chinese include reference of man's psychiatric ailments. The depression of King Saul, delusional state of Nebuchadnezzar, Ulysses' madness for justifying his absence from the Trojan War, alcoholism of King Cambyses, "Phrenzy of Hercules" and the torturing Furies of Ajak are some of the oldest examples of human abnormality. These, of course, relate to the disorders of the great men. Obviously mental sufferings of the common men have slipped off into the obscure oblivion of the hoary past and did not find place in the historical records and literary documents.

The effect of cultural patterns upon the form of mental disorders have been a problem of interest to the cultural anthropologist for many years. Early in the present century it was believed that the study of existing primitive tribes, relatively untouched by civilization, would make it possible to gain valuable insight into the origins of abnormal behaviour. However, contemporary anthropologists ordinarily do not subscribe to the evolutionary theory of culture. The primitive tribes in the world today are no longer thought to represent "primitive"
qualities in an evolutionary sense. The anthropologist is more interested in the cross-cultural differences which are related to cultural change and child-rearing practices.

Anthropological research into personality disturbance in other cultures is a complicated matter. While some of the earlier cultural anthropologists were trained in psychiatry, psychiatrists with anthropological expeditions were often unskilled concerning the data and techniques of cultural anthropology. Fortunately, increasing emphasis on interdisciplinary training has made this problem less serious.

Emil Kraepelin (1896) was one of the first specialists in mental illness to interest himself seriously in the problems of comparative psychiatry. He toured a number of countries and observed forms of mental disorder in a large mental hospital in Java. He was particularly interested in learning whether the influence of climate and other tropical conditions of life modified the symptoms of mental disorder. He found that Europeans born and reared in Java presented exactly the same clinical types of mental disorder as those seen in Europe. However, Kraepelin observed symptoms among the natives that not only formed special clinical groups but also coloured the character of the more common forms of mental disturbances.

Freud's work in psychoanalysis, probably more than any other single force, stimulated interest in the anthro-
pological study of personality disturbances. In his book Totem and Taboo (1919), Freud suggested that the behaviour of primitive man is in many ways similar to that of the psychoneurotic. He argued that the magical practices and irrational rites which make up primitive man's system of taboos may be linked with the obsessive thoughts and compulsive actions of the neurotic patient in contemporary society. However, the validity of this hypothesis has been questioned by many social scientists.

One of the first signs of contact between anthropology and psychoanalysis was a review of Totem and Taboo which appeared in the American Anthropologist in 1920. While the reviewer remarked on the importance of psychoanalysis, he criticized Freud's belief that the Oedipus complex is the key to culture and society. He wrote: "This book is keen without orderliness, intricately rather than closely reasoned, and endowed with an unsubstantial convincingness." (Kroeber 1920). Many critics of Freudian doctrine have made similar charges.

In 1924, a distinguished British anthropologist, C. G. Seligman, gave further impetus to the growing mutual interests of psychiatrists and anthropologists in the problems of culture and mental disorder when he chose the topic "Anthropology and Psychology: A Study of Some Points of Contact" as his presidential address to the Royal Anthropological Institute.
A field investigation of the South Pacific culture of Papua (British New Guinea) was made early in this century when the Papuans were considered to be at a Neolithic, or Stone Age, level. The inhabitants were found to be of an excitable and extroverted temperament with no evidence of mental disorder other than brief outbursts of maniacal excitement. The investigator favoured the hypothesis, already advanced in the eighteenth and nineteenth centuries, that mental disorder is an outgrowth of cultural tensions in which economic and religious factors play an important part. He believed that true mental disorder in Papua occurred only where the natives had been disturbed by, or were in conflict as a result of, Western influence (Seligman, 1929).

A classic study of the psychoanalytic outlook applied to a primitive community was published by Malinowski (1927) in his book Sex and Repression in Savage Society. A study was made of the natives of the Trobriand and Amphett Islands in the South Pacific. The inhabitants of the two islands were similar in race and in language, yet the Trobriand Islanders had considerable sexual freedom, while the Amphett group lived under strict prohibitions. The rate of neurotic reactions was low among the Trobrinders and high among the Amphett Islanders. This finding was viewed as evidence in support of Freud's hypothesis that sexual repression is the critical factor in the etiology of neurosis.
While a few studies were reported early in this century by American psychiatrists, it was not until 1920 that anthropologists began in earnest to apply theories of psychopathology to ethnological and anthropological problems. Since that time, American anthropology has been influenced to a large extent by the Freudian theory of psychoanalysis.

Ruth Benedict (1887-1948) made the first clear statement of the effects of culture upon abnormal behaviour; and one of her students, Margaret Mead (1901-1978), was the first American anthropologist to organize research along psychiatric lines. Benedict showed that Melanesian society is built on traits which would be regarded as paranoid in a Western culture. The members of the group look upon one another as purveyors of "black magic", and the women would never think of leaving their cooking pots unguarded. The extent of the paranoid thinking is seen in the standard polite phrase of acceptance of a gift, "And if you now poison me, how shall I repay you for this present?" (Benedict, 1934).

Other anthropologists also made early contributions to social psychiatry. One investigator made a study of the Melanesian Island of Dobu and commented on the fact that the sexual freedom exercised there appeared to discourage personality disturbance having sexual content. "I did not see or hear of any one such case in Dobu. Although in the
Admiralities, which has a prudish sex life without individual freedom, I both saw and heard of many. There were many aberrant persons in Dobu. But apart from pathological jealousy in a few cases, aberrations took non-sexual paths" (Fortune, 1932).

Another pioneer was a psychiatrist who did field work among the tribes of South Africa. He pointed out the importance of mythical figures in the native explanations of psychotic behaviour, in the delusions of hospitalized patients, and in the dream life of normals. These figures included oversexed dwarfs, snakes lurking in the female sexual organs, and blood-eating and oversexed birds. The imagery and the interpretation of it by the natives was highly suggestive of Freudian concepts (Laubscher 1938).

Early anthropologists and psychiatrists have reported the virtual absence of certain mental disorders in some primitive social systems. Moloney (1952:36-37) believed the Okinawans to be relatively immune to psychoses and quoted others who have described the Dyaks of Borneo, the Lepchas in the Himalayan Mountains and the natives of Truk Island as being relatively mature emotionally. Weinberg (1952:228-232; 255-258) points out that Robert Paris, Cooper, Devereaux, and Seligman claim schizophrenia to be rare or nonexistent in homogenous nonliterate societies having minimal contact with Western cultures. Ellsworth Paris thinks this to be true for the Bantu people of the African Congo forest.
because of their intimate social relationships. Devereaux attributes the relative rarity of observed cases of schizophrenia in such cultures to their consistent value structure. Kardiner reports a virtual nonexistence of depression and suicide among the Alorese. Similar observations were made by Carothers in Kenya, in East Africa. Laubscher found cases of schizophrenia but no manic depressions among the Tembu people. Carothers and Seligman speculated further that schizophrenia tends to become manifest in those primitive populations who are exposed to close culture contacts with Europeans and are, as a result, experiencing drastic social changes.

Although initially, the study of the Hutterites (Eaton and Weil, 1956) of North America, an isolated Anabaptist religious sect in which there is social harmony and economic security, showed that there was not even a single member who was admitted into a mental hospital, a careful screening of the entire population brought to light the fact that 2.3% either had symptoms of mental disorder or had recovered from such a condition. Apparently even the most protective and well-integrated society provides no complete immunity against mental disorders. There is ample evidence from social, psychology, sociology, medicine, and anthropology which makes plausible the theory that culture and social relationships are major dynamic factors in mental health and disorder.
One of the most important studies of mental deviance in a relatively primitive African culture was undertaken in rural Ghana by a British ethnographer who took her medical degree and was trained in clinical psychiatry. When she investigated the shrine cults of Ghana, she had an unusual opportunity to observe mental disturbance among the Ashanti natives (Field, 1960). This psychiatrist established herself near a shrine where people came for help from a priest who communicated advice from a god, and she was able to obtain case histories on a number of supplicants who were mentally disturbed. Among the most important of her findings was that depression, which had been reported in earlier studies as being extremely rare, was in fact a most common symptom. Her work supports the idea that while mental disorders differ in the cultural form they take, their causes are probably very much the same from one culture to another.

CHILD-REARING PRACTICES AND MENTAL DISORDER

The cross-cultural approach is also concerned with child-rearing practices in various cultural groups. There is a large and important segment of scientific authority which maintains that mental deviance later in life can grow out of such practices as lack of breastfeeding, a curtailed period of nursing, abrupt weaning, an overly rigid nursing schedule, premature toilet training, infrequent mothering,
excessive punishment, and similar actions which operate to make the child feel unwanted, unloved, insecure, inadequate, and frustrated.

It has been shown that the suspicious and unambitious qualities so pronounced in the personality of the adult Alorese are in part a function of the way in which their infants were handled (DuBois, 1944). They were nursed at irregular intervals, their discipline was unsystematic, and there was a general lack of consistency in training. At one time an infant would be picked up and caressed if he cried; at another time, the same infant would be left to cry without the slightest attention being paid to him. The erratic and unpredictable treatment of the infant was believed to result in an adult with distinctive personality characteristics.

Among the Pilaga Indians in the Argentine of South America, there is complete sexual permissiveness from early childhood. All sexual activities within the family are carried out in full view of even the youngest children. Since there are no prohibitions placed on the sexual activities of children, they are completely free to do as they please. Both heterosexual and homosexual activities are carried out openly from early childhood. In such a completely permissive atmosphere, problems later in life seldom are related to sexual frustration (Henry and Henry, 1944).
A study of the possible effects of child rearing on later mental health was made in Okinawa. Fewer than 250 mental patients were found in a population of approximately 350,000. There appeared to be a minimum of psychosomatic disorders, and surgeons rarely reported shock reactions or fainting spells. Also, some of the organic changes due to emotional tension seen in the culture were not reported by pathologists in Okinawa. It was observed that Okinawan mothers were seldom separated from their children. The children were breast-fed whenever they were hungry or in pain, and the mothers did not force bowel training. There was no physical punishment; the infant was regarded as a human being with more rights than an adult. The investigator suggested that the emotional stability of the adult Okinawan was to be explained by these early, satisfying life experiences (Moloney 1945).

While the finding in connection with parental attitudes and maternal deprivation have sometimes been conflicting, work with animals has made it clear that the nature of the infant-mother relationship may have important implications for the later development of healthy and unhealthy personality characteristics. In a study of unusual interest, a University of Wisconsin psychologist raised infant monkeys with artificial mothers (Harlow, 1960). One group of monkeys was reared with wire "mothers" which were hard, cold, and unresponsive. A second group of monkeys
was raised with mothers made of terry cloth and foam rubber. These mothers were soft and warm, but they were also unresponding. It was found that the cloth mothers demonstrated an extraordinary capacity to instill feelings of security in the young animals. Further experiments showed that infant monkeys reared with wire mothers found it difficult later on to develop normal social and sexual companionship with other monkeys. It was not expected, however, that the monkeys raised with the terry cloth and foam rubber mothers would have this same difficulty, since these infant monkeys showed a very strong affection and attachment to the foam mothers. Yet these monkeys also had difficulty in establishing normal emotional relationships with other monkeys. The findings suggest the possible critical role of the responding parent in the development of the well-adjusted personality.

The weight of evidence indicates that child-rearing practices may influence an individual's susceptibility to emotional disturbance. While the manner in which this influence is exerted is not clear, one of the principal impacts of child-rearing practices may be in the area of stress tolerance. An examination of various practices under experimental conditions, and in different cultures, suggests that some of these practices increase the threshold for tolerating stress, while others decrease this threshold. It is impossible, however, to say with any
degree of certainty which child-rearing practices are ultimately beneficial and which are ultimately destructive in terms of an individual's later emotional stability and mental health.

As noted earlier, cross-cultural studies suggest that while there may be wide differences in the surface symptoms of mental disorder, the underlying processes may be very similar. This indication gives additional support to the position that there may be a physical basis for some of the more serious conditions. Since a number of the milder mental disorders also appear universally, eventhough they are much more susceptible to cultural conditioning, it is also possible that there may be a constitutional basis for conditions of this type.
CULTURAL RELATIVITY OF MENTAL DISORDERS

Ruth Benedict (1934) pointed out that some behaviour (trance, possession, visionary experience, homosexuality) which is considered abnormal in Western society is held to be normal in others and vice versa. A suitable illustration used by Albert Beguin and quoted by Ellenberger (1959) which is given below, clarifies this concept.

"Let us imagine that a man, barely covered with a loincloth, frightfully emaciated, the face painted in red and blue, scratching his vermin, should squat at the corner of a "mairie" in Paris and remain there for hours and days, chewing a few grains of millet, sometimes humming, but most of the time without moving or speaking. If at least he were begging, his behaviour could be understood, but he is not ... It is most likely that he will soon go through the gates of the Sainte-Anne mental hospital...But this man-I have seen him a hundred times in India; The faithful were gathered in front of him, staring at him in the hope of receiving some emanation of his wisdom. - A man is insane relative to a given culture."

A man with strong achievement motivation and initiative might be branded as a witch by the Zuni. We have also movements like the Gay Liberation Front which aims to remove the "sick" label which society has affixed to homosexuality and to promote a more relativistic view of
deviant behaviour. Taking drugs for unusual psychedelic experiences has become popular in some segments of the Western World. Should those who do so be characterized as "abnormal?" Should we adopt a statistical view of abnormality, counting those who deviate from a norm as "sick" persons? Benedict counseled against such an approach. Erich Fromm (1944) even argued that the majority of persons in a society may suffer from "culturally patterned defects" associated with behaviour which is culturally approved but which may be emotionally crippling. Fromm, then, would tend to have an absolute view of emotional health, transcending cultural differences, in keeping with a fulfillment model of personality. Fromm (1955) has made use of multiple criteria to gauge the relative sanity of societies: not just hospital admission rates, but also rates for suicide, homicide, and alcoholism.

Opler (1967:266-267) states "In New York City, we found people who had never been known to psychiatry or psychological medicine who were as utterly incapacitated as any I have seen in chronic wards." Oddly enough opposed to this remark is a comment by Braginsky, Braginsky, and Ring (1969), who found schizophrenic patients on chronic wards to be quite normal; ...."they did not appear to us to be the disoriented, dependent, and socially inept creatures that the textbooks described."
The sickness model of mental health has been associated with a taxonomy of disorders, like those for organic ailments. We have terms like manic-depression, schizophrenia, hebephrenia, catatonia, hysteria, neurosis and many others. The putative advantage of such classifications is that a differential diagnosis should lead to a specific course of treatment. A drawback, however, is that different psychiatrists often apply different labels to the same patient. Walter Mischel (1968) observes that although it is possible to get reasonable agreement among raters for very broad categories of deviant behaviour, such as "organic" "psychotic" or "characterological", less gross psychiatric classifications cannot reliably be made.

Karl Menninger (1963), who has campaigned for nearly 50 years against the psychiatrists' urge to classify mental disorders, argues that the best way of conceiving of mental illness and health is as a continuum with the sicker persons ranged at one end and the "weller" ones at the other. All persons, in his opinion, have mental illness of different degrees at different times.

A number of authorities have stated that very few cases of depression appear in Africa. Both Carothers (1948) and Tooth (1950) explain this rarity by saying that there is a relative absence of self-blame and guilt among Africans. M. J. Field (1960), however, found depression to be the most common mental illness among women in rural Ghana.
Field did not work in a hospital but attended shrines where anxious persons came for help. She interviewed such individuals and accumulated abundant case material. It is Field's belief that African women suffering from depression would not be apt to go to a European hospital; hence the rarity of reported cases.

W. Lloyd Warner (1958) has described a man called Laindjura, a member of the truly "primitive" Murngin tribe in Northeastern Arnhem Land in Australia. Laindjura is famous in the Southeastern Murngin country as a killer and sorcerer. He described many of his murders to Warner. These murders could not possibly have taken place as the man described them. Laindjura tells of Tomahawking a young girl between the eyes, after which he pushed his arm up through her vagina, pulled out some of her intestines, and grasped her heart. Laindjura collected some of her heart's blood and sprinkled ants on the girl's intestines, which stood out several feet. Then he pushed the intestines back into her body and fixed up the wounds so that nothing untoward was visible. After this, the girl got up. Laindjura told her that she would live for two days and then die. She went off to gather lilies with some other women, and Laindjura heard them laughing. Two days later she died.

This is only one of several such stories told by Laindjura, each of which is full of similar ghoulish detail. Warner is certain that Laindjura believed a great part of
these stories. If that is so, isn't Laindjura insane? The mere fact that the alleged murders follow traditional cultural patterns does not make Laindjura a normal man. Yet, his fellow Murngin tribesmen do not regard him as peculiar, and Warner says that he was not very different from the ordinary man in the tribe, although perhaps a bit more alert. "He was a good hunter as well as an excellent wood carver, and had several wives and a number of children. There was nothing sinister, peculiar, or psychopathic about him; he was perfectly normal in all of his behaviour. This seems hard to credit, in view of his stories.

The Saora of Orrissa in central Eastern India are hill people who feel themselves to be much inferior to Hindus. They believe that after death they go to a vague sort of place where life is much the same as on earth, although the quality of the palm wine is not as good. Hindus, on the other hand, go to a more splendid afterworld, where they live in palaces and fly about in airplanes. It sometimes happens, however, that a Hindu in the other world takes a fancy to a living Saora girl and appears to her, asking her hand in marriage. Verrier Elwin (1955) collected many autobiographical accounts of such courtship, telling of exciting rides through the air with Hindu suitors on horseback or by airplane, and other dramatic episodes.
Perhaps we may shrug off these accounts as the erotic dreams and fantasies of shy young girls. But the important point about these fantasies is that for many Saora they persist for a lifetime. If the girl continues to refuse her suitor's hand in marriage, she falls ill. Her parents therefore arrange a wedding with the invisible groom. This makes the girl a shaman. Henceforth she has contacts with the other world through her husband's mediation. She may become possessed; then he and other spirits speak through her. The same applies to men who become shamans by marrying Hindu women in the other world. The shaman whether male or female, may marry a living Saora and have children. But they also have children by their spouses in the other world. The Saora women suckle them at night. They keep track of progress of their children in the other world as they grow older and tell stories about them.

We are faced here with the same problem as in evaluating the behaviour of the Murngin sorcerer. Both the people themselves and the ethnographer in each case judge the individuals in question to be normal. Perhaps this is the right approach since in each case the behaviour is culturally patterned and they are not held to be pathological by members of the society.

One of the questions raised is whether different cultures tend to bring about different types of mental disturbance. It is evident that there must be some cultural
patterning in at least the content of delusions and hallucinations. A person must have some familiarity with European history, however, slight, if he is to arrive at the notion that he is Napoleon. An unacculturated Eskimo who develops paranoia will have to be mad in a somewhat different way, although the underlying structure of his ailment may be the same as in Europe.

CULTURE SPECIFIC DISORDERS

In studying mental disorders in non-Western societies one can either look for manifestations of the traditional neuroses and psychoses of the Western world and so classify mentally disturbed individuals, or else one can approach the subject from the indigenous viewpoint. Such a study can throw light on both the stress points and the susceptible groups in a particular culture; it is also useful in increasing our knowledge of how cultural factors contribute in general to mental health and illness.

Among disorders which appear to be culturally patterned are "Windigo", "Latah", "Imu", "Saka", and "Pibloktoq". These ailments appear to be sufficiently distinct, so that the native terms for them have been retained when they are discussed in the literature. A justification for dealing with these quite often described syndromes is that some new points of view about these disorders have been expressed in recent years, and these deserve to be examined.
The "Windigo" or "Wiitiko" psychosis is a form of disorder formerly found among Chippewa, Cree and Montagnais-Naskapi Indians in Canada, characterized by cannibalistic impulses and delusions. In these cases the affected individual, who is usually deeply depressed, may believe that he has been possessed by the spirit of a Windigo, or cannibal giant with a heart or viscera of ice. He may also have symptoms of nausea, anorexia, and insomnia and may see the people around him turning into beavers or other edible animals. Indeed, the disorder has been attributed to the experience of starvation and isolation in wintertime, (Landes, 1939; Cooper, 1933; Rohrl, 1970, Brown, 1971).

Seymour Parker (1960) is skeptical of this explanation for two reasons. First those who suffer from the psychosis are not always threatened by starvation. Secondly there are peoples, like the Eskimo, among whom starvation is a frequent danger but where no analogue of the Windigo psychosis has developed. Hence Parker suggests a psychoanalytic interpretation, influenced by Abram Kardiner's view, in which the pattern is ultimately traced to frustrated dependency needs in childhood. The prototype of the cannibal giant is seen to be the frustrating mother. Parker accepts a statement by Landes to the effect that women rarely succumb to this ailment; it particularly affects men who have had repeated failures in hunting. Parker
suggests that such men feel abandoned and worthless, not only because they have no food, but because they feel deprived of their power.

Morton Teicher (1960) has canvassed the available literature on the "Windigo" psychosis and has identified 70 cases. Most of the cases were from northeastern Canada and occurred in the 19th century. In 44 of the episodes cannibalism actually took place; it was a real threat in the others as well. About half of the "Windigo" sufferers were killed by members of the community. Of the 44 cases involving cannibalism, members of the immediate family were eaten in 36 cases. Teicher believes that this is because of the nature of the social order, with small isolated families often living alone. Forty of the 70 cases were males; 29 were females, and in one case the sex was not specified. Teicher estimates that, at least 25 of the 70 cases were associated with famine conditions. In these cases the term 'psychosis' seems to be inappropriate, for Teicher points out that these individuals killed from hunger sometimes had the support of others in violating the taboo on cannibalism. It was only in their later behaviour that members of this group showed mental disturbances, which would suggest a different psychodynamic picture for the development of the disorder in these cases.
"Latah", "Imu", "Saka" and "Pibloktoq", are grouped together since they have a number of features in common and are generally considered to be forms of hysteria, primarily affecting women. "Latah", found in Southeast Asia and Indonesia, involves a startle reaction; the subject is easily frightened and may cry out. She then engages in compulsive imitative behaviour, repeating actions she has observed (echopraxia) or phrases she has heard (echolalia) (Loon, 1926).

David F. Aberle (1961) has described "Latah" behaviour in Mongolia, which is similar except that here men seem to be often the victims.

Aberle says that a man who has been frightened may shout obscene exclamations (coprolalia), especially words for male and female genitalia.

"Imu" is a somewhat similar condition found among the Ainu of Northern Japan. It particularly affects older women, although it is sometimes found among young girls. Winiarz and Wielawski (1936) report that its incidence is frequent. In three Ainu villages of 1,000 there were 12 "Imu" cases. In five of these the symptoms developed right after the woman had been bitten by a snake. Other cases were also related to snakes, either through seeing or dreaming about one. The attack may be started if someone pronounces the word for snake or any loud sharp sound. The woman affected may then curse and engage in excited aggressive behaviour or else run away in panic. Echopraxia and
echolalia also appear. As in Indonesia and Mongolia, the victim is aware of the incongruity of her behaviour, but cannot stop herself and she continues with her compulsive mimicry until she is worn out. Women often claim to feel better after an attack.

Not all writers agree classifying "Latah" and "Imu" as forms of hysteria. Tadeusz Grygier (1948) says that the symptoms of "Imu" correspond roughly to the Western standard of catatonia and not of hysteria. Benedict and Jacks (1954) take the same view of "Latah", and with some qualifications, of "Pibloktoq".

Marvin K. Opler (1967) classifies "Latah", "Imu", "Pibloktoq", and "Amok" as "nuclear forms of schizophrenias" which are open to spontaneous remission or curable by shamanism or other techniques. They could also be called forms of "hysterical psychosis" which are characterized by "a sudden and dramatic onset temporarily related to a profoundly upsetting event or circumstance. Its manifestations include hallucinations, delusions, depersonalization and grossly unusual behaviour.

"Saka" is described as a form of hysteria found among women of the Wataita tribe in Kenya. Grace Harris (1957) gives the following picture.

"Women beginning to have attacks of "Saka" sometimes show evident signs of a generalized restlessness and of anxiety. However, sometimes without any obvious warning
A woman begins the characteristic convulsive movements. The upper part of the body trembles but often the head and shoulders are more affected so that, while the shoulders shake rapidly, the head is moved rhythmically from side to side. As the attack continues the eyes may close and the face becomes expressionless. Some women perform certain simple acts in monotonous repetition, or they repeat strange sounds which are supposed to be foreign words. If there is singing or drumming or other music, the woman in "Saka" may move about as in a trance. There sometimes appears to be a loss of consciousness, and at such times the woman becomes rigid, her teeth are clenched, and she must either be supported or gently helped to lie down."

"Susceptibility to "Saka" attacks is so common among married women that in some localities as many as half the married women are subject to them at least occasionally. Some women claim and are acknowledged by others to have "Saka" very severely; others are subject to much milder attacks....The immediate events which bring on an attack vary, for each woman has her own sensitivities, though all of these fall into a pattern. Sometimes a particular sight smell or sound is responsible: the sight of a motor car, the sound of train whistle, the sight or smell of a cigarette, the sound of a match being struck, the sight of a bright piece of cloth, the smell, sight, or taste of bananas."
"Pibloktoq" is a disorder found among Polar Eskimo in Northern Greenland. It may affect both sexes, but more commonly women. The subject is at first irritable or withdrawn, then engages in a burst of violent excitement. He may shout, tear off his clothes, break things, and then run out across the ice. Friends and relatives chase after him and try to keep him from harming himself. After this period of excitement the subject sometimes has convulsive seizures and then may fall asleep. Upon awakening he may be perfectly normal and have no memory of the attack. In this respect there seems to be a contrast with "Latah" and "Imu", also in the lack of emphasis on echolalia and echo-praxia. "Pibloktoq" sometimes has a high incidence, especially in winter and a number of persons living in a small community may be afflicted in the course of a season, (Wallace, 1972).

There are other such disorders; for instance, the fear of sorcery which can lead, not only to sickness, but even to death (Cannon, 1942). There is the condition of "Amok", found in Indonesia and elsewhere, in which brooding depression succeeds to a dangerous explosion of violence. There is the anxiety state known as "koro", found in Southeast Asia (Linton 1956; Yap 1965), in which the patient is afraid that his penis will withdraw into his abdomen and cause his death. There is also the condition
known as "Susto", or magic fright, sometimes found in peasant communities in Latin America and the trancelike state reported for Formosa known as "Hsieh-ping" (Wittkower and Fried, 1959).

Even when we have a category of mental disorder, such as schizophrenia, under which patients may be classified in different countries there are variations in behaviour and characteristic symptoms from one cultural group to another. It has been noted by Wittkower and Fried (1959), that hospitalized schizophrenic patients are less violent and aggressive in India, Africa and Japan than in the Western world, and William Caudill (1959) has observed that reports from some non-Western countries, like Japan indicate that schizophrenic patients manifest less withdrawal than they do in the United States. An African psychiatrist reports that delusions of grandeur are rare among Yoruba paranoiacs, and he explains this by saying that Yoruba culture demands total allegiance and submission to ancestral cults and deities. In such a cultural climate, delusions of persecution may develop, but not those of grandeur, (Lambo 1955).

The existence of such culture specific disorders seem to show that most cultures have some traditional form or forms of aberrant behaviour. They are maintained over the generations by folklore, memory and gossip. People who display aberrant behaviour may be typed, let us say as
being "Windigo" even though this category may include a wide range of deviant behaviour. The existence of such a category and label may induce deviants to behave in ways that accord with the stereotype, especially when the deviant is in a confused suggestible state. As Thomas J. Scheff (1966:82) has put it: "In a crisis, when the deviance of an individual becomes a public issue, the traditional stereotype of insanity becomes the guiding imagery for action, both for those reacting to the deviant and, at times, for the deviant himself."

SOCIO-CULTURAL STRESSES AND MENTAL DISORDERS

Stressful experiences are often acceptable as rationalizations of most psychiatric illnesses, to the extent that most disorders go unrecognized in their insidious early phases, and are then intensified by stress, they often do appear first as the result of stress.

Kiev (1972) points out, that to the individual's basic biological patterns are added characteristic personality factors, which strengthen or weaken his ability to withstand various stresses. It is thus possible to visualize the development of conditioned responses to specific culture-bound stimuli.

It is here that culture plays a crucial role, for it is culture that influences both the nature and the per-
ception of stress, as well as the kinds of responses that have been developed for coping with it by members of the particular culture.

Psychologists have pointed out that, while specific stresses may be more characteristic of one culture than of another, it is the non-specific aspect of stress, or the conflicts inherent in the culture, that may precipitate psychiatric disorder in a vulnerable individual. Which particular disorder develops depends on the individual's constitutional predisposition, as well as his early experience and family history.

Culture is not only a system for the satisfaction of biological needs; it is also a system of psychological defences related to ego functioning. Cultural factors set limits on human behaviour to a greater extent than do biological needs. The environment and the individual are reciprocally related, in that, shifts in one tend to be accompanied by corresponding changes in the other. Perception of the environment may be altered by physical injury and abnormal psychological stress; conversely, changes in the environment may alter the individual's responses. Human being must define the nature of their immediate environment in order to be able to define their own place in it, (Kiev, 1972).

According to Montagu (1961) conflicting values are minimal in those cultures that provide institutionally
sanctioned means of expressing aggression, reducing anxiety and supporting dependency needs. The cultural context determines in large measure which patterns of expression will become institutionalized and which will become labelled as deviant. For example, co-operation, kindness, religious outlets for hostility, and the benevolence of the chiefs contribute to healthy behaviour in the Caroline Islands, while witchcraft techniques and ill-will, among the Dobsans in Melanesia, encourage paranoia, a psychosis characterized by suspiciousness as a useful trait for adaptation. This is particularly striking since the same behaviour may be decidedly maladaptive in another culture. Emotional withdrawal is encouraged in Bali, but it does not limit adaptation there.

It is quite clear that different cultures support or reinforce different psychopathological patterns, and also provide acceptable roles for their expression. This does not mean that such patterns are not psychopathological for they are likely to be rooted in the same inherited biological matrix.

The actual mechanism by which socio-cultural factors produce psychiatric disorders is difficult to specify. The formulations put forward by Leighton (1965) and Hughes (1969) are perhaps best illustrated by situations of social change, where the visibility of cultural
stresses and the need for methods of reducing anxiety are both increased, by virtue of the strain that is being put on the culture and the social system. Social change is accompanied by the intensification of social and cultural sources of psychological conflict, by new stresses and new adaptation requirements in new milieus, and by the loss of the stabilizing effect of old cultural patterns. Even the improvement of living conditions may not be without its deleterious effects: the environment may still be stressful, even though visible economic indicators of poverty and crowding are no longer present. In the United States, revolutions in automation, communication and transportation are highly valued and even equated with progress, and yet they are all clearly associated with discontent and turmoil.

CULTURE AND PSYCHIATRIC DISORDERS*

Many writers have stressed the significance of cultural factors in the distribution of mental illness. Seligman (1929) noted that confusional states characterized by the disorientation of one's surroundings were more common than systematized insanities among the Papuans of New Guinea, and that he could not find any cases there of

* For a better understanding of the Psychiatric Disorders mentioned in this section, refer to the classification of Diseases (ICD-8) in Chapter IV, p. 176-178.
manic-depressive psychosis in which outbursts of emotional displays of elation or depression are exhibited. Berne (1950) observed that toxic confusional psychoses or psychoses traceable to poisonings rather than the schizophrenias, the commonest psychosis were predominant among hospitalized Malaysians. Carothers (1953) related Westernization to an increase in manifest paranoid, or suspicious behaviour among patients in Kenya. Similarly Spiro (1952) took note of the fact that the Ifaluk in the Carolines had violent paranoid outbursts only after the Japanese occupation, while Slotkin (1956) emphasized the presence of paranoid schizophrenia among acculturated Menomini. Opler (1956) found that lower-class Filipinos had a high proportion of the affective disorders like manic depressive psychosis, neurotic depression etc., and catatonic confusional states like schizophrenia that were present among the Hawaiian hospitalized, while Carothers (1953) and Tooth (1950) both found in Africa statistically low incidences of depression and suicidal states, side by side with relatively high rates of confusional states among African natives.

The findings of significant differences in the content of the delusions or false beliefs of disturbed individuals in different cultures has contributed to an emphasis on the pathogenic effects of cultural factors. Careful examination of these delusional systems, however,
has frequently revealed their close relationship to the belief system that is prevalent in the culture.

As in the study of Laubscher (1938) among Africans in Queensland, the present study of the Maharashtrians of India also showed that schizophrenic symptoms included auditory and visual hallucinations, with mythological content, as well as delusions of grandeur, and of being poisoned and bewitched. The delusions of Europeans, by contrast, included influences operating from a distance, through electricity, telepathy and hypnotism. Similarly, Tooth (1950) found that the delusional content of 'bus' people in the North of Ghana was associated with the ramifications of the fetish system, whereas among the sophisticated people of the South of Ghana and, in particular, Accra, it included ideas of influence and control by electricity and wireless, along with messianic delusions and delusions of grandeur. Stainbrook (1952) has noted that lower-class Bahians in Brazil, where they are schizophrenic, suffer from anxieties and fears of retribution relating to African or Catholic deities, while the delusions of middle-class Brazilians are expressed in terms of economic and class conceptions of power, along with such impersonal influences as that of electricity and physical waves. Lambo (1955) found that delusions among rural non-literate Yorubans related to supernatural concepts and ancestral cults, while in literate Africans hypochondriacal
delusions characterized by real and imagined pains and organ malfunction were prominent. These considerations take on special significance when one is attempting to establish the relationship between cultural factors and psychiatric disorder.

The view that cultural factors condition the basic form and structure of psychiatric symptoms and illness has been in large part derived from reports of special transient forms of schizophrenia, along with a high frequency of hysterical disorders, and a low frequency of depressive disorders, in the developing cultures.

According to Lambo, (1961) African culture is characterized by belief in supernatural forces; faith in the magic of symbols; expectations of supernatural punishment; orally preserved tribal legends and mythological concepts with an emphasis on animism; full play of affective activity in daily life; complete identification with the group; lowering of ego boundaries and thought processes; ancestor worship; belief in the existence of idealized good objects; a tendency to regard dream life as objective reality; a simple, restricted, ill-defined and rudimentary usage of symbols, and strong religious belief. These characteristics seem to be suitable to a society in which ego boundaries do not have to be clearly maintained, because of heavy individual reliance on the support of the community.
It is quite likely that such undifferentiated ego patterns are related to the high frequency with which hysteriform and schizophrenic-form illnesses occur among Africans, when they experience the social change of urbanization.

Similarly, the frequency of confusional excitement and the low incidence of depression and suicidal behaviour in developing countries have been attributed to the outward rather than inner expression of hostility among the people. In fact, they appear to be similar to those catastrophic reactions, characterized by acute psychotic and confusional symptoms, that are seen in disaster situations.

Kiev (1972:62-63) suggests that, "Catastrophic anxiety is generally associated with inability to cope with the severe, life-threatening stresses of nature, sickness and death, as these are daily experienced in the developing countries, quite by contrast with the situation in industrial societies, where people are protected from them. Increasing urbanization in the developing countries, with its accompaniment of new living patterns and new adaptive skills, may lead to lower rates of acute confusional states, as people come to be increasingly protected from acute stresses. Self-restraint, emotional inhibition and compliance are essential for adaptation to the urban setting."
According to Wittkower, (1969) social and emotional withdrawal, which is common among schizophrenics in Asia, may be related to the Hindu and Buddhist teaching of withdrawal as an acceptable mode of reacting to difficulty. The high frequency of catatonic rigidity, negativism and stereotype among Indian schizophrenics has similarly been related to the traditional Indian passive-aggressive response to a threatening world."

According to Vahia (1962), the joint family system in India and the lack of emancipation contributed to the pathogenesis of hysteria in women. In so far as marriages are arranged, a woman is virtually in bondage for life; to improve her lot, her only recourse is illness. Hysterical fits attributed to supernatural forces are socially acceptable ways for the oppressed wife to gain sympathy and attention, as well as relief from her duties.

Slum dwellers in cultures of poverty and the lower socioeconomic classes tend to neglect the dependency needs of the young; in addition, they suffer from lack of adequate resources to care for the young. The consequent failure to develop skill in postponing gratification is not made up for by the development of group ties, as it is among some African cultures. As a result, one finds a high frequency of impulse disorders and oral deprivation patterns.
In most societies, women have considerable difficulty in developing independent patterns. They are not expected to contain their frustrations but are encouraged and expected to be emotionally labile and expressive. As a result, expressions of distress, unless they are exaggerated, as in hysterical symptoms, tend to be ignored or to be attributed simply to feminine behaviour.

Along these lines, Yap (1951) has noted that hysterical behaviour is most frequently associated with small cohesive groups, where face-to-face and communal co-operative patterns prevail, so that individual expectations of help are high, while individual striving for achievement is not stressed. There is a greater expectation of dependency-need satisfaction in such groups, than in the larger and less personalized groups of an urban industrial society.

"Beliefs and customs not only provide alternative explanations; they also furnish channels of expression for psychopathological disturbances, thereby rendering them psychodynamically understandable. To the extent that psychiatric disorder may thus go unrecognized or may be 'explained away' without treatment, complications may develop when the individual's culturally acceptable behaviour involves him in potentially noxious experiences. Conversely, beliefs and customs may lead many persons who have minimal situational problems - for example, in love, work and
fortune -- needlessly to seek help from fortune tellers, soothsayers and others who skillfully exploit the dependency needs of the troubled, (Kiev, 1972:71).

Various studies have pointed out that guilt feelings are rarely reported in the Philippines and in Japan but ideas of sin and suicide are frequently reported in many of the non-Western societies. Among Africans, depressive illnesses are frequently associated with confusional symptoms and are of shorter duration, while in Japan and other advanced societies, they are commonly associated with obsessive-compulsive disorders.

Lambo (1960) says that "depression is to be found in those cultures that enforce social control by way of abstract and situation-centered moral teachings, which are predicted on moral obligation. It is his notion that the individualistic, competitive and aggressively striving Protestant cultures may specifically produce unusual psychological stress, and that belief in original sin probably intensifies oppressive self-reproach in a superficial, pathoplastic manner."

Asuni (1962) has suggested that, while depression is common in Africa, suicide rates are low because of the lack of inwardly directed aggressive acts based on guilt-a sense of unworthiness and self-reproach. According to Baasher (1961) one third of the patients seeking psychiatric aid in Khartom, North Sudan, suffered from depression of one kind or another.
Thus, an examination of psychiatric disorders in different cultures suggests the existence of universal symptom patterns in major psychiatric disorders. What differs from culture to culture is the cultural colouring of beliefs, delusions and behaviour patterns, as well as differences in the kind, severity and location of pathogenic factors.

CULTURE CHANGE, CONFLICT, DISINTEGRATION AND MENTAL DISORDER

In the case of sociocultural change, it is almost impossible to pinpoint the specific effects of the many different factors involved, all of which are intricately interrelated (Murphy 1961). However, some suggestive evidence exists. Fortes and Mayer (1966) studied an African tribe that had been confronted with the need for major social adjustments; they reported a marked increase in mental disorders over the rate that had been obtained ten years earlier. In a neighbouring tribe that did not have these adjustment problems, the rate of psychoses had remained low.

Wallace, (1961) says: "... the position that culture change is associated with mental disorder has a certain obvious plausibility. But it must not be imagined that mere change in itself is so powerful a determinant that it will elicit sharply increasing incidences of
psychosis." Goldhamer and Marshall (1953) for instance, studied the trends in the incidence of institutionalized psychosis in America over a hundred-year period, and found that the rate of psychosis had remained constant, despite the accelerating rate of cultural change. However, according to Wallace (1961) there are sociocultural factors which are generally shared by all groups that display a high incidence of mental disorders which are often associated with culture conflict and culture change. Some of these factors are: low social status, economic backwardness, living close to advanced cultures, migrations, living in slum areas and lower racial and ethnic statuses. He also suggested that a combination of physical disadvantages such as inadequate diet etc., with social incompetence, shame and anxiety are important factors influencing the incidence of both the psychotic and neurotic diseases.

But, again, it is necessary to qualify. Margaret Mead (1956) has described the dramatically swift transformation of Manus culture which has taken place within a generation, but which has not, as far as one can gather from her book, been accompanied by any increase in mental disorders—unless the Cargo Cult in which many Manus participated be taken as a manifestation of such disorder. One gets the impression that, if anything, the Manus are happier now than they were in the old days.
To cite another example, Eric Berne (1959) reports that acculturation processes do not seem to have increased rates of mental disorder in the Fiji Islands. Citing census figures since 1911, Berne claims that such disorders were actually more frequent in the preindustrial, prewar era than in the recent period. Thus, there may be exceptions to the stressful nature of acculturation and culture change.

Observations made in various parts of Africa and in Haiti (Wittkower and Fried, 1959) show that, as rural, backward and tribal native populations enter urban areas, mental disorders increase in frequency and their clinical manifestations approximate those of the European white settlers.

There is also general agreement that radical culture change is felt by large sections of the affected populations as a stressful experience. A frequent result of stressful experiences of this kind is an increase in antisocial behaviour. However, differing responses to similar experiences have been noted in culturally distinct groups. Thus, in Israel, Jewish immigrants from Tunisia have a high rate of delinquency and of other forms of antisocial behaviour whereas Yemenites have a low rate (Wittkower and Fried, 1959).

When two cultures come in contact, in some cases the two live side by side without meshing and in others one group is absorbed into the other. In the latter
process individuals often suffer. They are subject to value clashes. The solutions which one way of life has offered for generations must be given up and new ones accepted. Yet comparative cultural materials indicate that acculturation is not always a source of stress. In some cases it happens easily and at other times with great difficulty. It occurs with obvious mental health implications or with apparent simplicity. Some cultures resist change, and the members show little tension. Other groups, in the process of resisting, are unable to maintain their integrity as a psychological or social entity, (Allinsmith and Goethals, 1956).

With reference to the integration of culture, Leighton, (1961) points out that "... wherever one finds a closely integrated culture, and an individual not in tension with his culture, one will find a minimum of psychotic and neurotic disturbance, whereas a disintegrated culture leaves its members without interpersonal and cultural support thus leading them to various forms of stresses, tensions, frustrations and ultimate psychosis or neurosis."

According to Leighton, the community units that are markedly disintegrated will have:

1. High frequency of broken homes
2. Few and weak associations
3. Few and weak leaders
4. Few patterns of recreation
5. High frequency of hostility
6. High frequency of crime and delinquency
7. Weak and fragmented network of communication

Many other views about specific sociocultural tensions or stresses that are likely to have negative effects on mental health have been written, (Leighton and Hughes 1961; Wallace 1961, 1967; Wittkower and Dubreuil 1971; Guthrie 1973; Kiev 1972 and Yap 1969). However, only a few of the major factors have been discussed above.

According to Dubreuil and Wittkower (1976) the others that are related to culture which need to be mentioned are: excessive numbers and intensity of taboos, excessive strength of some values, cultural discontinuities (Benedict (1949), dysfunctional role replacement (Wallace 1961), excessive exposure of individuals to simultaneous statuses, role deprivation, and basic personality structure. Still others pertain to social organization: anomie, rigidity of structures and minority status.

The literature of various disciplines document the claim that mental illness is found in all human societies, that the rates of mental illness are higher in some societies than in others, that certain cultures predispose their members to specific psychopathological patterns and that culture and social relationships are dynamic on causal factors in producing socially deviant on mentally disordered
individuals. The available data also lead to the inevitable conclusion that culture per se, taken in its broadest sense, is a universal source of psychological tensions and conflicts.

The foregoing pages have briefly reviewed the major anthropological concepts and theories that are relevant, but often ignored, in studies of socio-cultural and psychological determinants of disordered behaviour.

In the present study, it has been clearly observed, that the traditional customs, legends, mythologies, superstitious beliefs, social stratification and the values of a culture, determine to a large extent, the normal and abnormal mental states of its members.

The study also suggests that a mental derangement would possibly take place when a heavy load of tensions or the cumulative effect of a number of socio-cultural and psychological tensions are met with by individuals of a culture who can find no other alternatives to stabilize their unbalanced and stressful state of mind.

Thus, we find that by and large, it is the culture of the group, that conditions the mind to meet the various crises for adjustments to be made by its members. The researcher is in total agreement with John G. Kennedy (1973) who said, "Only by massive, concentrated, and sophisticated cross-disciplinary efforts can the theoretical riches latent in the cross-cultural approach to mental disorder be discovered."