A Survey of Cross-Cultural Determinants of Mental Disorders

Janet Lesniewski

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A SURVEY OF CROSS-CULTURAL DETERMINANTS OF MENTAL DISORDERS

by

Janet Lesniewski

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
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The challenge encountered in the preparation of this thesis has been intellectually satisfying and will hopefully open doors for further research in this area. Without the encouragement and advice of my Committee Chairman, Dr. Robert Jack Smith, its completion would not have been possible. My thanks is also extended to the other members of my committee, Dr. Norman Greenberg and Professor Arthur Helweg. In addition, I would like to thank the entire staff of the Kalamazoo Consultation Center for their encouragement and assistance, with special thanks to Grace Roth, Lynn White and Nancy Ray. For their unique contribution to me during the writing of this manuscript, I dedicate this study to Dr. Walter Stump and Dr. Eugene Ballard.

Janet Lesniewski
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CHAPTER I

THE PROBLEM

The Nature of the Problem

Few today can fail to acknowledge that the recognition and treatment of mental disorders are becoming matters of grave concern, not only for members of the medical professions but for all those who deal with human problems at any level. However, the problems involved in the demarcation between mental health and mental illness, as well as between the various types of mental disorders, are extremely complex, and this complexity becomes magnified when one is involved with individuals from cultures other than one's own.

As Hallowell (1934) points out, if we are to assume that certain classes of disorder appear in every culture, but that the incidence of the various disorders differs from culture to culture, or that the content of the symptomatology varies, then we must recognize that cultural factors must play a role in the etiology of such disorders. Holding to the general biocultural theory, Wallace (1960) notes that since each culture will provide the individual with a given set of theories about the cause and nature of his illness, as well as the methods of therapy to be employed, it is reasonable to assume that the frequencies of different illnesses will vary from culture to culture.

These two statements taken together may seem a tautology, but it is important to remember that even such biological functions as eating
are culturally influenced. In an area such as mental disorders, where there is as yet no commonly held opinion as to its biological basis, it is especially important to keep in mind that, even if biologically determined, cultural factors do indeed play a role. This is especially true since culture defines the appropriate emotion for a given situation, the form in which the emotion may be expressed, and the degree to which the response is to be expressed or inhibited in that particular culture (Hallowell 1938).

Statement of the Problem

The purpose of this study is to investigate the notion that while mental and emotional problems exist among all people, the incidence of certain types and the symptomatology of the different types vary among the many cultures as a result of differences in certain cultural practices. In addition, differential treatment of certain groups within a given culture appears to affect the type of disorder most likely to occur and the incidence of disorder within that group.

The method of investigation to be used for this study is a search of the literature for reports dealing with the incidence and symptomatology of mental disorders in different cultures. Following this a review of pertinent cultural data will be undertaken, especially that pertaining to child-rearing practices. Then, through a cross-cultural and cross-sexual comparison of the data thus obtained, it will be determined if any consistent trends between certain child-care practices and certain emotional problems are indicated.
Hypotheses

The hypotheses to be tested in this study are as follows:

HYPOTHESIS I: That the type of symptomatology most commonly expressed by individuals in a given culture will be at least partially determined by culturally approved behavior; that it becomes pathological when it is not expressed in culturally approved contexts.

HYPOTHESIS II: That the degree to which different cultures have certain mental disorders in common will vary according to the extent that certain cultural practices are similar.

HYPOTHESIS III: That the expectations of a child will differ according to whether the child is a boy or girl.

HYPOTHESIS IV: That differences in behavior of males and females will yield differences in symptomatology exhibited during a mental disorder.

HYPOTHESIS V: That the difference in the incidence of illness between males and females will vary relative to the degree of difficulty in adapting to different expectations.

HYPOTHESIS VI: That the degree to which an individual is isolated from the norms of the group in which he was raised will enhance the chances of his behavior deviating from the norms of his new group.

It will be considered that any of the hypotheses of this study will not be upheld if the following conditions prevail:

1. If the behavior exhibited as part of a pathological syndrome cannot be found in any context to be used by an individual held to be mentally healthy, the hypothesis may be held to be invalid.
2. If, in a cross-cultural analysis, certain mental disorders are held in common with no corresponding similarities in certain cultural practices, the hypothesis may be held to be invalid.

3. If, in a cross-sexual analysis, significant trends for differential treatment do occur without a corresponding difference in incidence or symptomatology of emotional problems, the hypothesis may be said to be invalid.

4. If, in the majority of cases, groups of individuals isolated from the norms of the group in which they were raised do not show an increase in the incidence of mental disorders, the hypothesis may be held to be invalid.

DEFINITIONS

The following definitions will be used for terms used throughout this paper:

Culture.—Opler (1956:14) defines culture as "...an imposing and conditioning variable which always becomes internalized, in one way or another, in the psychic systems of human beings." For the purposes of this study, culture is assumed to concern behavior patterns.

Mental Disorders.—Mental disorder as defined by Kaelbling (1961:10) is "...the individual's inability to conform to the role-expectations that are held by his community or himself."

Voluntary Psychopathology.—Voluntary psychopathology is to be considered those cases referred to by Kaelbling which are induced by the use of drugs, alcohol, induced trance states, and similar conditions which are in some way consciously sought by the individual.
**Organic Disorders**—Organic disorders will be considered to be those disorders arising from known physical causes, such as physical trauma, senility, infectious diseases and birth defects.

**Need for the Study**

At present there are many differences of opinion as to what conditions should be classified as mental disorders. As indicated by Zubin (1960), identical terms are frequently used among professionals, but with different meanings being understood. He noted that in a work conference held in 1959 by psychiatrists from several countries, this problem was discussed at length. Hohman presented to the group the difficulty encountered in assessing the recovery rate of schizophrenia under existing systems of classification, where at one hospital this was given as 70 percent, the Navy rate of recovery was given as 50 percent, while in his own group he found the recovery rate to be zero percent. At the same conference Lilienfeld brought to the attention of the members a point made by Hoch concerning a study of the diagnosis of first admissions in one state over a period of time. The results of this study showed that there was a change from 5 percent to 95 percent for the diagnosis of schizophrenia and from 95 percent down to 5 percent for manic-depressive disorders.

Today psychiatry has been infused by the concepts of other related fields, each with its own vocabulary, each questioning the psychiatrists' long held traditions. This infusion has brought an increasing awareness that "mental and emotional disorder reflects not only the biological and physiological organization of the patient himself, but is equally
a reflection of processes in the society in which he lives" (Hinsie and Campbell 1970:v). The study of these processes is an area for which the anthropologist is uniquely qualified.

Early workers in the field of Culture and Personality held to the Freudian point of view that isolated events such as nursing, weaning and toilet training were the foundation upon which later mental disorders were laid. However, as pointed out by Linton (1956), it is now generally held, as a result of research in the field, that such isolated incidents are less significant in the development of personality than the attitudes which accompany the various stages through which an individual must go. It appears that if we are to gain a true perspective, we must investigate cultural factors of a more general order, and the pathology that exists within the culture, in order to determine where the stress points lie (Opier 1956). Before committing ourselves to any generalized statements "...such factors as the psychological patterns of males and females within specific cultures, the intergeneration conflict or harmony, and the emotional climate of the typical 'ethnic' home must first be known" (1956:35).

Despite the widely recognized need for studies dealing with the correlation between various cultural practices and the types of mental disorders that tend to arise within the context of these cultures, few studies of this type have been done. Of those that have been done, the majority compare, at most, two different cultures or sub-cultures and their way of life in relation to one or two types of mental illness. In order to obtain a more comprehensive picture, studies of a broader and more coordinated nature must be undertaken. This study is an initial
Limitations of the Study

The limitations of this study are as follows:

1. **The difficulty in defining mental illness.** This is especially pertinent in a cross-cultural study of mental illness, as what may be recognized in one culture as a mental disorder may in another be considered appropriate behavior. However, this problem is no longer thought to be as significant as it once was.

2. **The use of data which are not comparable from one study to another.** This difficulty arises as a result of investigators using different methods and measuring different phenomena. Some researchers will measure the incidence of mental disorders, others the prevalence rate, some will study all admissions to a hospital, others only first admissions. In reporting their results some authors lump all of the mental disorders together, while in other cases schizophrenia may or may not be broken down into the subtypes. As noted by Rin and Lin (1962), what is needed is a more systematic and standardized way of reporting data. However, in this study I have for the most part merely noted trends rather than any absolute statistical similarity.

3. **Differential treatment within a culture.** Since any age, sex or social group may receive differential treatment, the probability of certain mentally ill persons coming to the attention of a mental health worker may vary according to age, sex, social class or other factors.

4. **The samples used.** Since the relative percentages of different
age groups may vary from culture to culture, the incidence of mental disorders which are found more frequently in a given age group will be affected according to the percentage of people in that age group. Thus, senile psychosis may be expected to be encountered infrequently in a culture with few aged persons, and this in turn would affect the percentage of mental disorders found which occur primarily among the young. As I have eliminated from this study those disorders known to have an organic basis, the effects caused by such direct factors as longevity, diet and disease in a population have been minimized to the greatest extent possible.

5. People likely to be hospitalized. Since individuals suffering from certain disorders, such as schizophrenia, are more likely to be hospitalized than those with more benign illnesses, these individuals are more likely to be over-represented in hospital populations, and thus more likely to be statistically counted than others. However, this variable is partially cancelled out by the fact that this would tend to hold true regardless of the culture being studied so that the relative, even if not absolute, frequency of the various disorders should be comparable cross-culturally.

Organization of the Thesis

The thesis is organized in the following manner:

Chapter I deals with the nature of the problem and the limitations involved in a study of this type.

Chapter II deals with the procedure used in this study. It describes the disorders, and the cultural practices studied, and the
rationale for these choices.

Chapter III deals with the "exotic" disorders, or the culture-bound syndromes, and some of the cultural practices found in the groups where these occur.

Chapter IV deals with schizophrenia and its subtypes and describes cultures in which the various subtypes are found with greatest frequency.

Chapter V is concerned with the study of the paranoid symptomatology in general and the conditions under which this is found to occur.

Chapter VI is concerned with the results of the study.

Chapter VII is a summary of the study.
CHAPTER II

PROCEDURE

The purpose of this paper is not an attempt to determine why a
given individual within a culture might become victim to a mental
disorder, but is rather an attempt to discover, if possible, how an
individual learns the specific behavior in that particular culture
that would make it possible for him to be considered as suffering from
a given mental disorder. Since any behavior which is displayed by the
mentally ill can be found in normal persons within certain contexts,
it appears that the main differentiating feature between mental health
and mental illness is that the mentally healthy individual displays
the behavior in an appropriate context whereas the mentally ill fails
to do so. Wallace (1960) in speaking of the schizophrenic individual
sums this up nicely:

"Society and the medical profession, are not wrong in their
judgement that these very sick schizophrenic persons not mere­
ly do not, but cannot, maintain the system of culturally ap­
propriate behavior. Even when aspects of their behavior are
evidently part of the cultural repertory, these 'correct' acts
are done in 'incorrect' situations...the behavior of the schizo­
phrenic patient is, item for item, reproducible in normal per­
sons...

...Bizarre as the behavior...seems to be, it is the unsuit­
ability of the act to the situation in which it is performed,
rather than the act itself, that makes the behavior bizarre...
The cultural incapacity of the schizophrenic patient is accord­
ingly a decrement in his ability to assign already learned
meanings and to perform already learned tasks in the culturally
recognizable situations" (702-703).

The mental disorders should be considered as correct behavior in an
incorrect context does not appear without basis when one considers that
Virchow, the founder of cellular pathology, as quoted by Yap (1967:175)
defined disease as "physiology in the wrong context."

Many authors have commented on the similarity that exists between hypnosis and some normal states as well as the behavior exhibited by persons under hypnosis and persons suffering from mental disorders, especially the schizophrenias. West (1960) noted that not only was the dissociation that is present in the hypnotized subject also found in all of the dissociative reactions, but also in individuals who were daydreaming, concentrating, or suffering from highway hypnosis. Erickson (1939) noted that amnesia and compulsive and obsessive behavior could all be induced by hypnotic suggestions.

Erickson (1939:62), commenting on the phenomenon of catalepsy in the hypnotic state, noted that "In the stuporous trance, this catalepsy may not be distinguishable from the cerea flexibilitas of the stuporous catatonic patient." The similarities noted by King (1957) between hypnosis and schizophrenia included disorders of thinking (concrete and bizarre answers to questions), blocking, impairment of the critical faculty of the mind, condensation, distortion, neologisms, impulsive acts, disturbance of affect, ambivalence, disturbances of sensation and perception, distortions of the body image, hallucinations, delusions, and a peculiar "staring" quality of the eyes. Wexler (1951) also noted this state of fixed gaze in schizophrenics and compared it to a similar phenomenon found in hypnosis. Bowers commented on this relationship between the two states. She notes:

"At times one has the definite feeling that schizophrenics are in a kind of perpetual state of auto-hypnosis...These patients seem to have learned the tricks of inducing a state of auto-hypnosis in order to withdraw from the vicissitudes of outer reality. It is theorized that they have learned such tricks in order to limit their perception of outer reality and in this way maintain their distorted inner reality..." (1961:43).
Given these features of mental disorder that can be found also in normal individuals in certain situations, it is not surprising that the question is frequently raised as to whether mental disorders can be studied using cross-cultural comparisons. The view that some disorders which may not be defined as such by some peoples should not be held as examples of mental disorders by those in the field is denied by Cerny. He states that "Cases in which the boundary between mental health and illness was shifted would be signs of bad psychiatric practice rather than ideology. In practice a good psychiatrist should always and everywhere recognize the quality in similar fashion"(1965:649).

Workers in the field are becoming increasingly aware that cross-cultural comparisons can be made. As noted by Gussow:

"Recent studies in culture and psychopathology negate the view that there are 'bizarre native psychoses,' that mental illnesses are 'unique' to the society in which they occur, and emphasize instead cross-cultural parallelism in the structure and process of mental disorders. It is the specific content of mental disorders which is held to be related to a given time...reflecting differences in prevailing beliefs, customs, traditions, interests and conflicts"(1960:218).

Yap (1951) believes that one of the reasons that the concept of abnormality is confused is that it contains a notion of judgment (good or bad, which may differ from culture to culture), and is a reference to the statistical average. As he notes, the framework of the schizophrenic processes remains the same regardless of the culture in which it is found. Murphy et al (1963) empirically showed this in their study which contained information on over 90 cultural samples. This showed that four signs and symptoms of schizophrenia were never reported as infrequent in any of the samples, and thus these four signs might serve as minimum criteria for a diagnosis of schizophrenia. These signs were 1) social and
emotional withdrawal, 2) auditory hallucinations, 3) delusions in general, and 4) flatness of affect.

The three main areas of psychopathology on which attention was focused in this study were the culture-bound reactive syndromes, the four main subtypes of the schizophrenias, and the paranoid symptomatologies. Excluded from this study were the organic and the voluntary disorders. The rationale for excluding the organic disorders was based primarily on the fact that the number of variables which would be operating in problems of this type would make such a study almost impossible in the context of this paper. Such factors as nutrition, longevity, endemic diseases, brain damage brought about by the use of drugs or alcohol, or constitutional defects are beyond the purview of this paper. The voluntary disorders were excluded primarily because they do not fit the definition of mental disorders as defined for the purposes of this study.

Also excluded from this study for the most part were the manic-depressive psychoses and the neuroses. There was little information on these two groups, and that which was available was presented in such a way that it was much more difficult to determine the differences in specific symptomatology as viewed from culture to culture than was the case with the disorders which were selected for study. For the most part, it was felt that at this point little could be gained from including them in the study.

This study was carried out by a review of the literature dealing with the various disorders as they appear in the different cultures. The symptoms which accompany these disorders were reviewed, and the cultures and circumstances in which these disorders are generally recognized as being...
more prevalent were then studied. The main focus of attention was on the structure of the family, the play of children, and child-rearing practices.

As contemporary sources are frequently not available for cultural material, as is the case for China for periods following 1949, the sources used for this thesis cover a fairly large span of time. However, it is felt this is not a significant factor in assessing the results of this study. The traditional practices of the cultural areas would have had more influence on the adult individuals included in the studies on mental disorders than would the more contemporary child-rearing practices. To maintain consistency in this thesis, the ethnographic present has been used in discussing cultural material.

In addition, although most post World War II work has been done with regard to psychological anthropology in Japan, which tends to modify if not refute Benedict's findings, and particularly her method, her work is included because of the massive number of references to it on the subject matter of this thesis.

Rationale for the inclusion of the play of children

From numerous studies which have been done on animals (Poirier 1972; Harlow and Harlow 1965; Brandt et al 1971; Wolfheim et al 1970) it appears that to ensure the normal development of an independent, integrated, and well-adjusted animal, mothering, peer group interaction, and a rich environment are all necessary, although any one taken alone is preferable to none in providing some degree of socialization. Each species of primate (including man) has within its social organization
provisions which guarantee the young will receive those skills necessary for survival in its group. Play is one of these provisions.

"Play...is a very broad term which includes almost any activity which, to the observer, seems to have no immediate objective" (Hall 1968:89). It is an activity which primarily occurs among mammals and probably does not exist in invertebrates, fish, amphibians or reptiles (Dolhinow and Bishop 1972). The importance of play in the socialization of a youngster cannot be underestimated. "Socialization operates on the total organism within a specific context. The processes of socialization are ongoing and may be termed 'maturation within the social milieu'" (Burton 1972:29).

One important function of play for the young infant is the development of motor skills. Many adult behaviors are difficult or impossible for the infant to perform, but with the repetitious nature of play, the infant gains practice in combining various patterns of movements and gestures in different ways and so gains familiarization with those behaviors he will need as an adult (Dolhinow 1972). During play, males and females learn different as well as the same skills. A number of motor skills and social relationships are identical for both, but in play those activities involved in the development of gender roles are also practiced (Dolhinow and Bishop 1972).

The long period of time in which the primate infant is dependent gives him ample opportunity to learn the complex behaviors he will need as an adult (Jay 1965). An optimal period appears to exist in which this learning can best take place (Lancaster 1972). This period begins when the infant first leaves his mother for short periods of time and joins...
his peers in the play group. In the play situation the youngster develops behavioral maturation. Within this context he learns to cooperate with others and establishes social bonds which may persist for years. He learns the limits of his self-assertive capacities, and the social interaction with others causes him to make behavioral adjustments which will enable him to function within the social organization of his group. If he is denied the opportunity of adequate play he will lack the necessary social skills and may be excluded from the group (Poirier 1972).

Although the studies dealing with this topic were primarily concerned with non-human primates, human societies do recognize the importance of play for children in the process of socialization. As noted by Deng in reporting on the Sudanese, "...Although the Dinka do not have institutions for formal education and training, the process of growth is educational. Games are not only played for fun; they are a means of disposing and adjusting children to the norms of society" (1972:65).

Rationale for inclusion of child-rearing practices

Although learning continues throughout the lifetime of an individual, it is during the years of childhood that the matrix for all subsequent learning is laid down. An infant is born into a culture where certain role behavior is expected of him, and he acquires this behavior in response to that of those with whom he associates. Thus the roles he acquires will be partially defined by the social behavior of these others. His earliest interactions will be with members of his family, and this is where many of the child-rearing practices will be executed, and these may differ widely from culture to culture. As noted by Erikson (1950)
there is some leeway between the care needed by a child to keep him alive and the actual care he may receive. Each culture determines what is workable within these limitations, and that which is considered as good for the child will be determined by what he is to become, and where. Some practices chosen may be adequate for maintenance of life, but may also provide a framework within which mental disorders are likely to arise.

Solovey and Milechnin (1959) state that there are two basic types of emotional states in the newborn infant from which the many nuances of emotional reactions of the adult will be formed. These two types are the stabilizing type which is physiologically mediated by the parasympathetic nervous system, and the disturbing type which is mediated by the sympathetic nervous system. In cases of extremely intense emotions, both types may lead to a condition of stupor or one resembling the hypnotic state. In order to obtain a normal psychophysiological development, an individual needs an adequate balance of both types of emotion. An insufficient amount of the type of stimuli that produce either the stabilizing or the disturbing emotional reaction may result in disorders of various kinds.

One example of the type of behavior which is designed to bring about the emotional reaction of the stabilizing types is the caressing by the mother or other caretaker. An emotion of the disturbing experience is experienced by the young child, as described by Bowlby (1953), who experiences separation from the mother. At this stage he is in a state of acute stress. If, in addition, he is
denied the ordinary care and attention necessary, he is especially likely to develop disturbed behavior. One factor which may increase the likelihood of this lack of attention occurring is the behavior of the child, which, during the separation, may include rejecting any attempts of others to care for him or provide him with comfort. In addition, the whining and temper tantrums frequently exhibited by a child in such a situation do not make it easy for surrogates to show him care of a positive type. In this way, the actions of the child toward his environment partially determine the type of treatment he is likely to receive.

The following three chapters will deal with the types of interaction displayed between adults and children, and between children within their peer group in given cultures, and the types of mental disorders which more frequently arise within these cultures.
Chapter III

Culture-Bound Syndromes: The "Exotic" Disorders

The Purpose

We have seen that human behavior that allows the individual to interact within his group is culturally patterned. Aside from instinctual behaviors, which in the human are few in number, the human child must learn his behavior from members of his family and community. We have indicated that what he learns will be partly determined by what is present for him to learn from and partly determined by what he chooses as important to learn from the range of behaviors to which he is exposed. The first of these is primarily determined by the culture in which he is born, the second is primarily determined by personality traits and idiosyncratic ways of perceiving the world. Three primary ways have been discussed, which are provided within the culture by which he can learn. These are: Imitation of others, formal learning through customs and traditions verbally transmitted, and play within his peer group. The matrix for all subsequent behaviors, normal and abnormal, is laid down during these early interactions.

Perhaps some of the most intriguing of the mental disorders are the so-called "exotic" syndromes. These, above all other mental disorders, appear to be patterned according to the culture in which they are found. As a result, Weidman and Sussex (1971:84) propose that they should be called simply "culture-bound reactive syndromes" that
would include the syndromes of latah, koro, susto, amok, neqi neqi, and windigo psychoses.

The idea of cultural patterns having an influence on the pattern- ing of mental disorders is not new, but was proposed at least as early as 1934 by Cooper. Hallowell, also in 1934, stated that "...hypothetically, it would seem that the character and incidence of at least certain classes of mental derangement must bear some relation to the cultural pattern" (1934:2). As indication of this he further states "The same mental disorder...may occur in different cultures but the particular form which its symptoms take may be a reflection of these cultural differences" (1934:3). This latter point was recognized by Weidman and Sussex (1971) when they pointed out that most of the "culture-bound reactive syndromes", whether of hysterical origin or not, remain specific for a given culture, so that Eskimos have piblokto, the Malayans have amok and latah, and the Cree have the windigo psychosis. Even among such widespread illnesses as schizophrenia, the incidence of the various sub-types of the disorder appear to be culturally influenced (Murphy et al 1963).

Because of the value these culturally bound syndromes have for research into the way in which cultural factors influence the symptomatology of mental disorders, it appears important for the moment to disregard the question of whether they are considered pathological within the culture where they appear in order to learn how these specific patterns of reaction and interaction are learned by the individuals who use them. Cultural explanations of these disorders as being possession or the result of masturbation, or any other explana-
tion, are only conjectures or speculations and will not help us as scientists to determine in what ways the clusters of behavior contained within these various syndromes are learned. For this reason, we must not look to the individual case history to find out why a given individual is suffering from a mental disorder, but first we must look to the culture to find out how any individual could learn that behavior. Only behaviors within one's repertoire can be used. Thus, we must know what is available for learning within the culture.

Yap (1962) states that while some forms of mental illness are definitely organic, still others are at the other end of the continuum. One of the most notable of these is hysteria which appears to be one of the most psychogenic of all disorders. It varies most with the culture and it appears to have an element of gain for the victim. In fact, he says that "...culture capitalizes upon it to such an extent at times, that I am led to wonder if some conditions of 'pseudo-psychotic hysteria' should be considered illness at all" (1962:169). As Barnouw (1973:7) points out, "In some ways cultural behavior is like that of persons under post-hypnotic suggestion, who perform actions without realizing why they do so." Although it is the individual who gets sick, Costello (1970) sees that it is the cultural beliefs rather than traumatic life situations of the individual that condition what objects and situations the community is to fear. The individual then acts in a culturally patterned idiosyncratic way in response to these conditioned fears.

Traditionally, when one begins looking for the etiology of a mental disorder, the considered place to begin is in determining the
state of the Ego of the individuals so afflicted, or on a broader
basis, the cultural ethos. Both of these are abstract terms which
are difficult to define operationally. For this reason, I propose
to look within the culture for behaviors which are positively sanc­
tioned at some point in time within the individual lifetime, and yet
which, when exhibited at a later period of time by the individual,
will be considered evidence the individual has deviated from the
behavioral norm. As childhood is the time when the majority of cul­
turally determined behaviors are learned, I will concentrate on this
period and will focus on five of the major culture-bound syndromes
and those cultures that predominantly display these syndromes. These
five syndromes are:

1. Amok
2. Latah
3. Piblokto
4. Windigo psychosis
5. Koro

The Disorders and the Cultures

Amok

Amok is a Malay word meaning "to engage furiously in battle" or
"to attack with reckless resolution" (Adams 1950-52:6). It is princi­
pally found among the Burmese and in Malaysia, but has also been re­
ported in Papua-New Guinea, Laos, the Islands of the West Indies, parts
of Africa, Siberia and Europe. In 1901, Gimlette listed four symptoms
which he held were cardinal features of true amok. These included a period of depression, a loss of control resulting in homicidal inclination, a persistence in the homicidal attack with no apparent motive, and amnesia following the attack.

Galloway (1923) believed there existed two well defined types of amok. The first type included those cases where the individual felt some blow to his self-esteem and as a result committed a homicidal attack on a person for whom he had negative feelings. This initial attack continued into a riot of murder until the attacker was brought under control or was himself killed. The second type mentioned was usually brought about as the result of a loss or bereavement. After a period of brooding the attacker turned on anyone in his immediate vicinity, killing indiscriminately. If the attacker survived, he suffered amnesia with regard to the event. The attack appears to have been a cross between suicide and homicide (Yap 1967) and the individual often killed himself or was killed by others (Teoh 1972).

Amok was first recorded by Captain Cook in 1770, at which time it appeared to be a frequent occurrence, one of his officers stating that there was hardly a week when one with amok did not have to be captured. The incidence of this syndrome is much less frequent now than it was in earlier times, but it is still not to be considered extinct (Teoh 1972). Traditionally, it was ascribed only to the Malay ethnic group; however, as indicated, cases have been reported from Papua and New Guinea (Yap 1967; Burton-Bradley 1968) which are a variant of amok and are called negi-negi or lulu. In addition, the Burmese have amok-like and latah-like responses. However, the symptoms
manifested are so consistent with what might be expected ordinarily of Burmese under stress of being startled, that the syndrome is not considered an illness and little stigma is attached to it" (Weidman and Sussex 1971:95). Westermeyer (1972) has noted that, traditionally, the Burmese have a continuum at one end of which extreme rage reactions occur (amok), and at the other end, extreme fear reactions (latah). Some authors have suggested an element of shame may be present in amok, implying loss of face for individuals in whom this is extremely important.

Latah

Latah, unlike amok which occurs only in men, is found in both men and women, but primarily in women (Cooper 1934). In a study of 150 physicians in the Dutch East Indies, 98 percent of the cases reported were women and only two percent were men. Van Loon (1927) noted that it especially seemed to appear in women who were employed as servants of Europeans, and he viewed it as a type of "monotonous" hysteria. As with amok, latah was seen as occurring only among the Malay, but Fitzgerald (1923) mentions it as occurring in Malaya, Java, Sumatra, the Philippines and Siberia, and it has been found that when Chinese are brought up with Malay customs they also may suffer from latah. A similar condition, imu, which occurs among the Ainu can be found in Japanese brought up from childhood in Ainu homes (Yap 1952). Yap also mentions latah-like conditions occurring among the Burmese (yuan), in the Philippine Islands (mali-mali), in Siam (bah-tschi), and in parts of Siberia (Arctic Hysteria).
The exciting causes for an attack of latah may be auditory, visual, or tactual (Fitzgerald 1923). In several cases tickling, or movement as if to tickle, was found to be capable of causing an attack. In fact, among the Siamese or Thais this tickling stimulus is what gives their name to the syndrome (Yap 1952). The literal translation of the Burmese name for the disorder, young-dah-hte, means 'to be ticklish and nervous' (Still 1940). Yap (1952:548-49) says it is "possible for latah patients to become susceptible to tickling in a culturally determined manner. Tickling, if prolonged, causes an accumulation of nervous tension in the individual which urgently demands relief. The natural outcome of continued tickling is the wild movements of defense and repulsion, and the spasmodic movements of laughter". Even so, tickling as a stimulus is not as effective as fright in inducing the symptoms, and the victims do not show much fear or anxiety when tickling occurs.

Several cases studied by Yap showed conscious imitation in childhood, and some of the speech mannerisms which occur in the disorder are present in normal Malay speech, although to a lesser degree than among the latah victims. Among both the Burmese and the Malay, it is so common to see latah-like behavior that most cases are not considered abnormal. Also, the high degree of suggestibility and imitativity seen in latah is also found in the daily life of the Malay (Van Loon 1927). Although the condition may provide some benefits to the individual, as people are frequently amused by latah (Yap 1952), still the patient wishes to get away from that which is affecting him, but appears to lack the will and the strength to escape (Fitzgerald 1923).
There are two basic groups of symptoms that occur, the imitation reaction and the "startle" reaction. The former includes echoing the words and actions of others, or carrying out commands (echolalia, echopraxia and command automatism). The victim will even carry out a behavior which may be harmful to self. The "startle" reaction occurs when the patient is startled or frightened and in response will jump, freeze, flee or turn on and attack the source of stimulus (Abraham 1912; Aberle 1952; Still 1940). Frequently, obscenities relating to the genitalia are shouted. Similar groups of symptoms occur in the young-dah-hte of the Burmése. The patient is extremely ticklish and will show a severe startle response. If struck, the patient will strike back with an imitative movement, returning the blow with the same force with which it was received (Still 1940).

The Cultures

Turning first to the Malay in order to study some of their culturally determined behaviors which might be present in cases of amok or latah, we will consider behaviors involving children. There is a great deal of ceremonial treatment following the birth of children. There is little difference between that for boys and girls; however, what differences do occur appear to favor boys, although girls are not unwanted. The child is weaned as soon as possible and is placed on a diet of banana, fruit-mash and rice-pulp quite early. From the age of two to six he amuses himself by playing around the house and runs small errands for his parents. At the age of six he begins to receive some education.
The boy is taught to be silent unless addressed, to keep his eyes downcast before superiors and to behave unobtrusively in public meetings. In fact, Wilkinson (1908) states, "...he creates difficulties by his very anxiety to avoid any expression of opinion that may seem to disagree with a view of the person addressed." On the other hand, Malay girls are usually kept shut up in their homes from the time they are ten years of age until they are married.

The games of the children are of interest for our purposes. As Hurgronje, quoted by Wilkinson (Part III:1) states, "In the games of children there survive dead and dying customs and superstitions of their ancestors, so that they form a little museum of the ethnography of the past." In addition, "...children, even grown-up children, are mimetic and show by their mimicry the features that strike them as remarkable in whatever they imitate" (Part III:4).

Nursery rhymes are frequently used with infants and young children. Meaningless words are often inserted into these for the sake of melody. The early games of childhood are quite simple. There are two tickling games where one child tickles the other and the one that can stand this tickling the longest is the winner. In addition, there are two pinching games, one game of knocking the fists together, and one where there is a form of slapping. Simple mimetic games are also common.

Among boys a little older, games are encountered where the boy is, by a form of hypnotic suggestion, led to believe he is some form of animal. The mildest form of this type game is main tikam emladang, "the wild bull" where the boy is not supposed to feel like a bull,
but merely to act like one. In main-hantu musang the boy drops to his hands and knees and a white sheet is thrown over him while the other players march around and around him stroking him and repeating a formula which is believed to hypnotize him, at which time he becomes possessed and unaware of what is happening. He chases others, climbs trees, jumps among the branches, and may get in a position where he might get injured, as he frequently goes out on limbs which are not strong enough to bear his weight. In a similar vein, in main kambing, or "playing the goat", he is also in danger of injury as he butts his head against walls and posts while in the trance.

Other amusements, apart from the games of childhood, include dances. Two of these are of particular interest to this study. The first of these is a marriage-dance, the "blossom-dance". Palm blossoms are laid on the earth, then a young girl is stretched on the ground and covered with a cloth while another girl nearby plays a musical instrument and sings to her. During this song the girl under the blanket is said to be losing consciousness and becoming possessed by the spirit of the dance. Following this, she rises as though in a trance, and picking up a blossom, dances with it as she repeats the words that have just been sung to her.

A religious dance performed by men, the main dabus, is more like a frenzy than a dance. During the excitement they stab themselves with a dabus (an instrument like a knife incapable of inflicting fatal wounds, although the wounds can be severe), and it is generally believed pain is not experienced during these frenzies (Wilkinson 1908).
Less information was obtained on the peoples of Laos, Burma, New Guinea and Papua, although all of these peoples may at times provide examples of *latah* or *amok*. No information on their games was obtained. However, the cultural patterns of much of the behavior directed toward children is similar for peoples of Laos and Burma, and for those of Papua and New Guinea. The former case is probably due to the influence of Buddhism in both cultures.

In all four cultures, the boy is preferred over the girl (LeBar and Suddard 1967; Vogel 1953; Yoe 1963; Davies 1969) and the treatment of the two sexes differs in that the ceremonies for the boys and girls after birth and up to puberty are more elaborate for the boys among the Burmese and Lao (Yoe 1963; LeBar and Suddard 1967), as well as in other areas.

Among the Burmese there is a belief in witchcraft and sorcery, as well as the belief that beings intent upon harm may possess a person. Individuals may experience trance possession either voluntarily or involuntarily (Weidman and Sussex 1971). An example of the former occurs during a yearly festival called *nat-win-de* which is held in parts of Burma. The chief feature of this festival is a dance in which the young women, or more rarely the young boys or men, dance. This dancing is accompanied by swaying movements made with the eyes closed, and after it is over, the dancers suffer amnesia with regard to the event (Still).

**Piblokto**

*Piblokto* is frequently compared with *latah*, arctic hysteria and
other disorders; however, a description of the symptomatology of the disorders shows that while all seem to have some features in common, some are more closely related than others. Cooper (1934) reported on the hysteria of the Eastern Cree and Northern Siberians. The former suffered a form of hysteria characterized by flight, often running from the lodge into the woods. There were also phobias, which included fear of leaving the lodge, going abroad, or going into the woods alone. The disrobing frequently found as part of the piblokto of the Greenland Eskimo and the echolalia and echopraxia of arctic hysteria were absent, but it was similar to these two disorders in that it occurred primarily in females and was rare among boys.

Arctic hysteria is found in Northern Siberia. It is rare among children, infrequent among men, and most common among women. The victims suffer convulsions, trance, coprolalia, fright, running away, echolalia and echopraxia. It is also not uncommon for the victim to attack the one assumed to have caused the attack. From the symptomatology it appears that arctic hysteria has more in common with latah than with piblokto.

Piblokto occurs among the Greenland Eskimos. It too, is more common among women and infrequent with children. No single or recurring symptoms are found, but there seems to be a series of behaviors which are displayed at various times. Gussow (1960) lists the most common symptoms to include stripping off all clothes and fleeing over the ice. Other symptoms include loss or disturbance of consciousness during the attack, amnesia for the attack, complete remission, glossolia, rolling
in snow, throwing oneself into the snow, acts of a bizarre but harm­
less nature, creating disorder, performing mimetic acts, and exhaustion
after the attack. As with hysteria in general, harm to self or others
is unknown, the attacks occurring only when the individual is not
alone and others are nearby to provide protection.

The Culture

Among the Eskimos, boys are preferred over girls, and female
infanticide may occur, sometimes to provide room in the family for more
boys. Children grow up free and unrestrained, getting their way most
of the time and never suffering punishment. They are taught their
future work by games which their parents play with them, and they help
in the house or in the hunt as soon as they are old enough. Boys are
feasted following their first kill. In contrast, girls are secluded
for varying periods of time during menstrual periods (Birket-Smith
1971).

The reactions that occur during an attack of piblokto are part
of the basic Eskimo personality. Due to the warmth of the houses,
near nudity is common when indoors. After a sweat-bath an individual
will lie down naked in the snow and roll around (Gussow 1960). One
of the basic rules is that children must undress quickly when indoors
lest a spirit look in the window and call at them, "You, in there
with all those clothes on, come outside!" (Rasmussen 1938:190).
Glossolalia and mimetic animal behavior are regular features of the
medico-religious functions (Gussow).
Windigo Psychosis

Windigo psychosis (also called wihtiko or wihtigo) is confined to the Cree, Saulteaux, and the Ojibwe Indians of North America. It is characterized by a belief that one can be transformed into a windigo, a creature with a craving for human flesh (Yap 1951). Among the Saulteaux it is believed that distaste for the usual foods, nausea and vomiting that persist for several days are an indication a person is turning into a windigo. Everyone in the community fears cannibalism, and the individual inflicted with this disorder may ask for death (Hallowell, 1934). Similarly, Cooper (1934) reports that an individual of the Eastern Cree who believed he had become a windigo because he craved human flesh would frequently ask to be killed. Among these people cannibalism has been practiced when hunger has become an actual threat. At these times the dead may be eaten so the living might survive. The symptoms among the Ojibwe of Ontario are similar to those of the Cree and the Saulteaux.

The Cultures

Among the Ojibwe most of the favorable attention is given to the boy. Almost from the day of birth the boy is told he must be a hunter and is given toy weapons. When he kills his first bird in play, he is given a feast. Men and boys hunt separately, and separateness, alone-ness, and self-sufficiency are stressed, especially among men. Both boys and girls are urged to fast in order to ensure dreams, but this is encouraged mostly in the boys from the age of four or five until
puberty. By the time he is eight a boy will often fast two meals a day every other day for periods of weeks at a time. If he is asked by his father what he would like to eat and he answers that he wants bread, he is cuffed, after which he must ask for charcoal. On occasion, the boys are sent out to an island or an isolated spot in the woods without food or drink for periods of four to ten days, where they are to attempt to have dreams. Frequently, by the time they are retrieved, they are ill from starvation (Landes 1938a).

The immediate cause of windigo is thought to be the threat of starvation on the winter hunting grounds. The man's family begins to look like luscious beavers. The man cannot eat or sleep and begins to brood, which in turn gives way to violence when he kills his family and eats them as a normal food object. Although it most frequently occurs in men, women who have been raised in the manner of boys by a proud father may succumb to the disorder. Females raised in the manner of girls do not fall victim to the disorder (Landes 1938a).

One of the favorite games of the children is playing house, and this is played endlessly until puberty. The girls attend each other as midwives, brew herbs, massage, and prepare special diets. The boys play at being shamans and have feuds, shouting and cursing their "enemies" that they will starve and have the windigo insanities. They then attack each other with knives and rejoice over the "death" of their enemies (Landes 1938b).

Skinner (1911) reported on the Cree and the Saulteaux. Among the Cree, children are never whipped but are allowed to do almost
anything that pleases them without any training from their parents. The women are subordinate and do the heavy labor.

The majority of games played by the children appear to be hunting games. One game, the square game, consists of a square drawn in the snow, in the center of which stands the person who is "it", (called the "cannibal"). The other players occupy the corners of the squares, and must attempt to run from corner to corner without being touched by the cannibal. If the cannibal touches anyone, that person becomes "it". Also, among the folk-tales of the Cree, many tales of cannibals occur.

The Northern Saulteaux have gotten many of their customs from the Cree, probably including that of cannibalism in times of famine. Children are not trained in any way except by example, and are not struck or reproved, although they may be praised to urge them on to greater effort. They are not weaned until four to six years of age. As with the Cree, the Saulteaux kill their insane persons.

**Koro**

The syndrome of koro (or suo-yang or suk-yeong) is the last to be covered in this section. It is a state of acute anxiety caused by the belief that the penis is shrinking into the abdomen, and that death will result when this process is complete. The traditional treatment was to tie a red string or small box to the penis until the victim could be taken for treatment. It is usually found only in males, although females have been reported that complained of the shrinking of the vulval labia and the breasts (Yap 1951; Yap 1965a).
Although traditionally believed to occur only among the Chinese, Yap (1965b) reported on a case in a British male and Edwards (1970) reported on an American schizophrenic male who had experienced the sensation of penile shrinkage. In addition, Gittleston and Levine (1966) found that in a group of 70 male schizophrenics, hallucinations and delusions concerning genitals occurred in 30 percent and 27 percent respectively.

The Culture

Among the Chinese, boys are preferred over girls. Infants are fed whenever they cry and are weaned at about one year. Thumb sucking is allowed but the child may be punished during toilet training. Children are rewarded for good behavior, and learn that a good child is humble, industrious, thrifty and honest.

Male masturbation, though considered normal, is viewed as bad, and Chinese parents warn their sons that masturbation will harm the penis. It is felt that the individual will suffer a defect of male sexuality, as nocturnal emissions and masturbation are believed to cause loss of the vital essence originating in the semen (Rin 1965). The Chinese belief is that during coitus a healthy exchange of yin and yang (the male and female principles) takes place, but with masturbation and nocturnal emissions this cannot occur, resulting in an imbalance of yang. This imbalance produces koro (Yap 1965a).

The anxiety experienced during an attack of koro is closely related to the belief "that the corpse has no penis because it is held that it could not have one. Hence a withdrawal of the penis into the
abdomen...must, in their belief, be a token of impending death” (Linton 1956:68 italics in original).

From the material in this chapter it can be readily be seen that the symptoms of mental disorders, especially those closely related to a specific culture, arise out of a background where these behaviors are part of the cultural repertoire. In following chapters we will examine what relationship, if any, exists between cultural practices and the schizophrenias, including the non-paranoid and paranoid types.
Schizophrenia: Distribution of Subtypes

Schizophrenia is defined as a group of psychotic disorders manifested by disturbances in thinking, mood and behavior. Symptoms may include delusions, hallucinations, social and emotional withdrawal, apathy, inappropriate affect, ambivalence and bizarre behavior. The traditional diagnosis recognizes four major subtypes; however, recognition of atypical types is becoming more common. These atypical types may be latent in that no psychotic schizophrenic episode has been experienced by the patient, residual in that the patient may no longer be psychotic but still retain some schizophrenic symptoms, or may be a mixed type in that the patient, in addition to the schizophrenic disorder, may display pronounced mood changes of elation or depression (American Psychiatric Association 1968). In the United States approximately 25 percent of all first admissions to public mental hospitals are diagnosed as schizophrenic, and due to the chronic nature of the disorder, about 60 percent of the patients in such a hospital are schizophrenic (Noyes and Kolb 1963:329).

The four classical subtypes are as follows:

1. Simple
2. Hebephrenic
3. Catatonic
4. Paranoid
Simple type

This type is characterized by a slow and insidious onset, apathy, indifference, mental deterioration, and adjustment at a lower level of functioning. Delusions, hallucinations, and intellectual impairment are not generally experienced (American Psychiatric Association 1968). Batchelor (1964) feels that this should not be considered a separate type as an individual who has had an attack of schizophrenia and recovered may be diagnosed as a simple schizophrenic.

Hebephrenic type

The hebephrenic diagnosis is made on the basis of disorganized thinking, shallow and inappropriate affect, giggling, silly behavior, speech disorders such as neologisms and verbigeration, mannerisms and hypochondriacal complaints (American Psychiatric Association 1968).

Catatonic type

Bizarre motor phenomena are the main characteristics of this disorder. The patient may be mute, withdrawn, stuporous, display "waxy flexibility", negativism, peculiar mannerisms, or sterotype; or he may be excited with restlessness, motor excitement and verbal overexcitability (American Psychiatric Association 1968). As opposed to the paranoid type of schizophrenia, the process types, hebephrenia and catatonia, are characterized by more global and diffuse cognitive dysfunction (Rubenstein 1974). In addition, the hebephrenic and catatonic types may have an overlapping of symptoms (Batchelor 1964), es-
pecially in the early and late stages. Both may display withdrawal, severe cognitive upsets, emotional lability and motor symptoms at the beginning of the disease, and some catatonics in the late stages of the disorder may show the deterioration of cognition or the incongruity which is associated with hebephrenia (Freeman 1969).

**Paranoid type**

This disorder is primarily characterized by the presence of delusions, hallucinations and feelings of passivity (being controlled by outside forces). Frequently, the patient is hostile and aggressive. Delusions of persecution and/or grandiosity are frequent (American Psychiatric Association 1968). Due to many factors, including sex, social class, age of onset, premorbid personality, tendencies to systemization of thought, mental deterioration, response to treatment, and intelligence Batchelor (1964) and Freeman (1969) would tend to exclude this type from the schizophrenias. Freeman notes that the diagnosis of schizophrenia is made easier and less often when these are not included. Batchelor (1964:12) also comments on the "withdrawn, uncouth, ungainly" appearance of the young schizophrenic as opposed to that of the middleaged paranoid psychotic who is often "alert, keen-mannered, normal in outward appearance", as well as the fact that when a psychosis is induced by amphetamine intoxication, it is always a state similar to a paranoid psychosis and never a catatonic or hebephrenic state.

Others also have noted these differentiating features. Abrams et al (1974) found that of 41 patients who had been diagnosed as paranoid schizophrenics on admission to the hospital, only two satisfied research
criteria for this diagnosis, fifty percent were found to satisfy the
criteria for mania (21 patients), and of the remainder, five were or-
ganic brain syndrome, six with an alcoholic state, four with personal-
ity disorders, two with endogenous depression, and one with a reactive
psychosis. Schizophrenics who satisfied both admission and research
criteria for a diagnosis of schizophrenia were younger, had more non-
auditory hallucinations, more first rank Schneiderian symptoms and a
smaller percentage experienced remission or improvement.

As a result of these studies, and others encountered in the course
of gathering data, I propose—with the exception of a brief discussion of
perceptual problems—to study paranoid symptomatology, including that of
paranoid schizophrenia, in a separate chapter.

Non-Cultural Factors Affecting
Normal Functioning

To function normally the brain needs not only access to already
stored material, but must have a steady supply of new experiences and
stimuli coming from sources outside the individual. A lack or defician-
cy of this input may be at the basis of some mental disorders (Pos et al
1967). A deficiency of sensory input may occur in one of several ways.
These include an actual decrease of stimuli, an overload of input with
consequent "jamming" of the circuits, decreased contact (pathological
or physiological) with the environment, and certain pathological pro-
cesses which may influence the sensory input regulating system so that
inadequate input may occur even in the presence of sufficient stimuli
(Brawley and Pos 1967).

The results of this phenomenon can be observed in many normal in-
individuals who are exposed to an inadequate amount of sensory input. It may result in hallucinations among truck drivers, high altitude jet pilots, radar sentinels, military sentinels, arctic explorers, and shipwrecked persons, as well as people engaged in other occupations with inadequate or monotonous stimuli. Religious rituals designed to bring about a mystical experience may use techniques such as isolation, confinement, and restriction of movements to achieve this end. Infants suffering from maternal or emotional deprivation may experience emotional upsets up to, and including, marasmus which may even result in death. But for purposes of this study, the area of most importance for involvement with informational underload is that of schizophrenia, which has many similarities in common with the symptoms of sensory underload (Brawley and Pos 1967).

Heron et al (1953) and Bexton et al (1954) based their experiments on the assumption that total sensory deprivation was not necessary, but rather that decreased variation in the sensory environment would be sufficient to produce changes in normal functioning. The experiment by Heron et al made use of translucent goggles and cardboard cuffs on the subjects while they tried to solve problems which were given over the loudspeaker. Results showed that they experienced difficulty in concentrating and suffered from visual hallucinations. During Bexton's experiment, his subjects (wearing translucent goggles and listening to humming fans) experienced boredom, impairment of concentration, emotional lability, and hallucinations ranging from simple to complex. In some cases, they experienced blank periods when they were unable to think at all. Immediately following the experiment there appeared to be an impairment of visual perception which included difficulty fo-
cusing, objects appeared fuzzy and two-dimensional, and colors seemed saturated.

Ziskind and Augsburg (1967) concluded from their study done with only the eyes of the subjects covered that hallucinations induced in this manner are actually normal imagery (such as that experienced during sleep, hypnopompic hallucinations, and daydreaming) which go unrecognized as such during the deprivation experiments due to reduced conscious awareness. After examining the range of cultural variations in hallucinatory experiences, no matter what their cause, Wallace (1959) concluded that the way in which the culture defines these experiences has a profound effect on how the individual (whether normal or mentally ill) responds to them, whether with fright, as a normal phenomenon, or as a religious experience.

An example of how culture may influence this can be found in the syndrome of kayak-angst as experienced by the Eskimos of West Greenland. This occurs when a male hunter is out alone in his kayak on a calm sea, with an absence of reference points, and when minimal or repetitive movements are required. Symptoms which are experienced include perceptual and cognitive distortion, impaired judgment as to distances, anxiety, a form of paralysis and delusions that the kayak is flooding with water, as well as fear of being attacked from beneath or behind. An individual who has had such an experience may develop a phobia and refuse to go out in a kayak alone as it is felt that if the kayak should tip while the individual is in such a state, he would be unable to save himself (Gussow 1963).

On the other hand, individuals from cultures where hallucinations
are felt to be part of a religious experience will actively seek such an experience. This may be seen among the Jivaro of South America who believe that hallucinations reflect the 'real' world; thus, they are sought after to such an extent that even newborn infants are given a mild hallucinogenic drug (Harner 1972).

Paranoid vs. non-paranoid schizophrenia

If changes in the sensory environment are able to produce symptoms similar to schizophrenia in normal subjects, it seems reasonable to suppose that individuals who are diagnosed as schizophrenic might be expected to have some problems in the area of perception. And it does appear that this is the case.

Houston and Royse (1954) felt that the results of deafness were such that the individual might experience paranoid symptoms since:

"Often not knowing what his fellow men are saying he becomes doubtful about them: losing auditory contact with them he has to rely on an inner world of auditory memories and images; he misinterprets auditory sense impressions which have been distorted by disease... If the personality is sufficiently unstable a psychotic illness results"(990).

To test this, the authors studied a group of 40 deaf psychotics and a control group of 40 non-deaf psychotics. They found a significantly higher number of paranoids among the deaf subjects than among the non-deaf (17 paranoid psychotics among the deaf compared to eight among the non-deaf).

Silverman (1964) tested the visual scanning of a group of paranoid schizophrenics. He found that while non-paranoid schizophrenics do relatively little visual scanning of their environment, the paranoid sub-
jects are extreme scanners. While the non-paranoid schizophrenic aims at decreasing the probability of encountering threatening aspects of his environment, the paranoid, with his hyperalertness to the environment and his tendency to amplify the intensity of what he perceives, increases his chances of encountering threatening stimuli. It appears this may serve as a means of avoiding or escaping threatening situations by becoming aware of threatening cues. The limited scanning of the non-paranoid may be adopted for use by the paranoid under long exposure to threatening situations from which no escape is possible.

In a study of the effects of hypnosis on REM (rapid-eye-movement) Weitzenhoffer and Brockmeier (1970) found that REM was decreased with the eyes closed, and much the same as that produced with eyes open in attention-producing tasks. They felt that waking REM might be a sign of vigilance by an automatic scanning of the environment to keep track of what is happening in the environment. Following from this, a decrease in the scanning activity may help the individual concentrate on the task at hand by cutting down on distracting stimuli from the environment.

Using EEG to test for alpha waves Nideffer et al (1971) found that schizophrenics produced only one-fourth as much alpha activity with their eyes open as normals. Authors believe this suggests that schizophrenics have more difficulty in withdrawing their attention from visual stimuli. As a result of this, they felt interference by visual stimulation might play a part in producing schizophrenia and concluded that people blind from birth might not become schizophrenic. They requested information from Denmark regarding the number of con-
genitally blind schizophrenics there and found that in the entire
country there was only one schizophrenic who was congenitally blind,
and in this case there was a question as to the diagnosis.

Eitinger (1960a) found that in a group of 35 blind refugees only
three were psychotic and all of these suffered from persecutory de­
lusions. In another study of blind persons, this one done on the day­
dreams of children, Singer (1967) found that the daydreams of conge­
nitally blind children were greatly limited in terms of variety and
complexity in relation to those of sighted children. It was found
that both daydreams and night dreams (auditory and kinesthetic imagery)
of the blind stayed close to their real life situations.

From this it may be suggested that perhaps when the ability to
judge a situation is impaired due to lack of familiar reference points
(whether caused by psychological or social isolation, culture shock, or
impairment of the perceptual processes) there is an inability to per­
ceive a situation as others might see it. Thus, the behavior of the
paranoid or schizophrenic may be normal for the situation as he per­
ceives it even though it may be inappropriate for the situational con­
text as seen by others.

Distribution

Although schizophrenia in general is found in every culture and
the framework of the disorder remains the same wherever it is found
(Yap 1951;1962), research studies have shown that the distribution of
the many subtypes may vary, and the most prominent symptoms displayed
during the course of the illness may vary from culture to culture
(Murphy et al 1963). One of the most probable explanations is that cultural factors play a role in influencing the course the disorder will take in a given culture (Margetts 1958). To test this assumption, I will do a comparative study of child-rearing practices in those cultures tending to produce similar disorders.

Simple and Hebephrenic Schizophrenia

As a general rule, in cultures where either simple or hebephrenic schizophrenia is the most common form of this disorder, the other will also be commonly found while, frequently, the paranoid form will be rare.

In groups studied, simple schizophrenia, delusions of jealousy and social withdrawal appear more frequently among Asians in general, with the exception of the Burmese (Murphy et al 1963; Sanua 1969). In Thailand 72 percent of hospitalized patients were diagnosed as schizophrenic, but the paranoid types were extremely rare (Ratanakorn 1959, 1960).

Among the Chinese simple schizophrenia is more common than the paranoid type (Sanua 1969) while catatonics are found less frequently (Cerny 1965; Lin 1953; Rin and Lin 1962). Rin and Lin also found more first born admitted with a diagnosis of schizophrenia, and more male than female patients, one study (Chu and Liu 1960) showing a male to female ratio of 3:2. Schmidt (1961) found that most hospital admissions in Sarawak, Borneo were Chinese with a diagnosis of the simple or hebephrenic type, with the simple type being the most common.

Although early workers in the field thought schizophrenia rare in Africa (Carstairs 1958 citing Faris 1937) more recent studies show
this is not necessarily true. Collomb (1959) found the simple type of schizophrenia common south of the Sahara, Collis (1966 citing Laubscher and Gillis) reported that both of these studies showed over 50 percent of hospital admissions in South Africa were schizophrenic and 26.6 percent in Tanganyika to be the same (citing Smartt). Shelly (1936) found similar results.

Hebephrenic schizophrenia is the most common and paranoid schizophrenia rare among the Okinawans, Japanese, Javanese, and the Sudanese (Murphy et al 1963; Sanua 1969 citing Pfeiffer 1962, 1963; Moloney 1954), with females being affected more frequently than males in all four cultures (Sanua 1969 citing Hankoff 1958 & Pfeiffer 1962, 1963; Kline 1963; Baasher 1961). Symptoms of social and emotional withdrawal were most commonly reported among the Okinawans and Japanese (Murphy et al 1963). Studies by Caudill (1958) and Schooler and Caudill (1964) show more psychological problems occurring among the oldest sons and youngest daughters among the Japanese.

While assaultive and agitated behavior is rare among the Okinawans (Sanua citing Hankoff 1958) Japanese females are likely to rave and be assaultive, although the males are generally well-behaved (Moloney 1954). Caudill (1958) describes the eldest son among the Japanese as being more rigid, constrained, and more likely to suffer from obsessive-compulsive disorders, depression and over-conformity, while the younger son is more outgoing, spontaneous and is more likely to develop problems in the form of acting out.

Among African peoples, the hebephrenic form was found to be the most common type in Nyasaland where the paranoid type was next most common
(Shelley 1936), Kenya where catatonic excitement and paranoid type also were found (Murphy et al 1963; Carothers 1947), in Guinea (Jakovljevic 1964) and among the Zulu Africans where the simple form was the next most common (Al-Issa 1970 citing Loudon 1959). In Kenya, where Gordon (1936) found 19.2 percent of hospital admissions to be schizophrenics, the male to female ratio was 3:1 (Carothers 1947). Here patients with the simple and paranoid types were difficult to distinguish from the hebephrenic form; however, the paranoid patients had delusions of a persecutory or grandiose nature. Shelley (1936) found 85.7 percent of the patients to be males with only 14.3 percent females.

Catatonic Schizophrenia

Catatonic schizophrenia is more frequently reported in India than elsewhere (Murphy et al 1963; Vahia 1963; Sanua citing Sukthankar and Vahia 1964). Catatonic excitement is most frequently reported among South Americans (Brazil, Peru, Colombia, Chile, Ecuador) and among Africans (Kenya, South Africa, Nigeria, Uganda) than by other groups (Murphy et al 1963). Catatonic schizophrenia is commonly found also in the Virgin Islands, apart from the French speaking groups (Weinstein 1962), and among the Muslims of Algeria (Sanua 1969).

Characteristics of the disorder as found among the East Indians included highest rates for the first born, more violence shown by females than males, and more admissions for literates (Sanua 1969), social and emotional withdrawal, and more stereotype and catatonic rigidity than reported from other areas (Murphy et al 1963).

In Bihar province, India, Rao (1966) found 69.9 percent of hospital admissions to be schizophrenics with about 37 percent of these
suffering from some type of delusion with delusions of persecution being the most common. Males more frequently saw the elder brother as the persecutor while females were more likely to see their mother-in-law or sister-in-law in this way. Although Gaitonde (1958) found only 8.53 percent of the Bombay patients in his study diagnosed as schizophrenic, this is probably due to the fact he was studying an outpatient clinic where the more seriously ill would be less likely to be seen. Dhunjibhoy (1930) reported that he found the catatonic and paranoid types to be more common in the educated, while the simple and hebephrenic types were more common in the uneducated.

Hoenig and Sreenivasan (1959) found males to make up the larger percentage of admissions to the hospital in Bangalore, Mysore state. Of the religious groups, Christians had the highest rates, while of the Hindu-caste groups the Vyshias (merchant class) had the highest rates with the Brahmins next.

Characteristic of South American groups were the frequency of catatonic negativism and flatness of affect (Murphy et al 1963). Stainbrook (1952) found patients in Bahia, Brazil, to be predominantly lower-class blacks and mixed-bloods, with behavior patterns showing both Brazilian and African influence. The patients, as in India, were found to be passive and submissive with little aggressive activity, although female patients were more likely to verbalize their feelings, aggressive or otherwise. Although avoidance-withdrawal behavior was common, it rarely led to a stuporous condition. As a general rule, the patients had little anxiety in regard to other persons, and paranoid ideation of impersonal forces acting upon one was found.
only among the educated middle class.

Sanua (1969) cited the reports of several authors on disorders in South America. Stein (1963) found little violence among patients in a Peruvian hospital where 80 percent of the patients were schizophrenic. Sequin (1964), also in Peru, found 66.7 percent of the patients in the hospital he studied to be schizophrenic and of these 52 percent were of the paranoid type. Bastide found the rate of schizophrenia in Brazil to be highest in the white population, lowest among the blacks, and a rate between these two extremes for the mulattos.

Characteristic features among Africans include flatness of affect (Murphy et al. 1963) and hallucinations of the visual and tactile type. In Ghana, where Tooth (cited by Collis 1966) found a percentage rate of 19.1 percent for schizophrenia, Forster (1957) found a rate of 35 percent. In his study, Forster found that out of a sample of 426 schizophrenics, only 57 were females. Symptoms included mannerisms, impulsiveness, uncontrolled behavior, apathy, inappropriate affect, negativism, and waxy flexibility. Delusions of persecution and feelings of passivity were common, especially among the most westernized. From the African and South American observations it appears that in these areas in addition to the catatonic excitement which is frequently found, paranoid symptomatology is often also common.

Atypical Schizophrenia

The undifferentiated, chronic type of schizophrenia was found to be most common in Lebanon (Katchadourian 1965 and Katchadourian and Racy 1967 cited by Sanua) with more males than females being hospital-
ized. This latter case is quite possibly due to the shortage of beds, leading to priority use by men.

The most frequently reported type found among the Malay schizophrenics in Sarawak, Borneo (Schmidt 1961, 1964), and the New Zealand Maoris (New Zealand Department of Health 1961; Beaglehole 1939) was the schizo-affective form. Among the Maoris more males than females were affected and the paranoid and hebephrenic forms were found to be rare (New Zealand Department of Health 1961).

Variables

Paranoid vs non-paranoid schizophrenia

Breen (1968) felt that the types of culture which would be more likely to produce individuals of the paranoid type of schizophrenia would differ from those producing individuals of the non-paranoid type. He felt that the individual most likely to have a schizophrenic reaction of the simple, hebephrenic or catatonic type would come from a culture where the emphasis was on the group, mutual help, family help, closeness among relatives with display of affection and avoidance of force, with hostility being expressed verbally. He felt that such an individual would be most comfortable when with others, be attached to his family even though his feelings might be ambivalent, and ask for and extend help when needed.

In contrast, he believed that the individual who would be most likely to become combative or paranoid when under stress would come from a culture where emphasis was placed on independence, aggression, and on getting the better of others in encounters. The family would

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not be the focus of attention and would have frequent disruptions due to fights among members. These are some of the variables that have been considered for this paper.

**Early Infancy**

Although children are almost universally desired, in the vast majority of cases it is the male child which is preferred. In none of the cultures here studied is a female child the preferred one, and only among the Javanese (De Waal Malefijt 1963) and the Jivaro Indians (Harner 1972) is no preference for either sex expressed, although among the latter the preferred order is a son followed by a daughter. Thus, sons are preferred over daughters among our samples in Kenya (LeVine and LeVine 1966), Thailand (Thompson 1941), Japan (Benedict 1946), Brazil (Hutchinson 1957), China (Yang 1945), Okinawa (Maretzki and Maretzki 1966), India (Minturn and Hitchcock 1966), Lebanon (Williams 1968), among the Dusun of Borneo (Williams 1969), and among the Dinka of Southern Sudan (Deng 1972). In all of these but Okinawa, and among the Dusun and the Dinka, sons are preferred by women, as having sons is the only way in which a female can gain prestige and status.

Sons are also necessary to carry on the male line and so are preferred by men, especially in the Sudan (Deng), China (Yang), Japan (Benedict), India (Sachchidananda 1964, 1965), and among the Gusii in Kenya (LeVine and LeVine 1966). In China or Japan a boy will be adopted for this purpose if none is born. The importance of sons among the ranchers in Northern Brazil is tied in with the importance for purposes of labor (Rivière 1972). Among our samples in China (Sidel 1972),
Okinawa (Maratzki and Maratzki 1966), Lebanon (Prothro 1961; Williams 1968), and in Japan (Embree 1939) the primary purpose of marriage is to produce heirs and the birth of a child, especially a son, is the most important feature in cementing a marriage.

Although they are not preferred, daughters are not unwanted as they will, in some areas, bring bride wealth at the time of marriage. This is true in several groups including the Gusii of Kenya, the tribal villagers of Bihar province, India (Sachchidananda 1964, 1965), and among the Dinka (Deng).

High infant mortality rates occur in most of the areas studied, and as will be indicated, the preference for male children affects this with much higher rates for infant deaths occurring among female children due to poor care, neglect and infanticide.

In China, female infanticide was (and in some areas is) quite common, and girls were less likely to get good medical care (Sidel 1972). Infant mortality rates are high for children under three years (Yang 1945) but more effort is made to cure a sick son than a sick daughter (Guthrie and Jacobs 1966) so that males outnumber females. Among the Japanese, while boys may be over-indulged, malnutrition is not uncommon in girls due to neglect (Naka and Kawakita 1965). Boys outnumber girls in Lebanon also, where the ratio of boys to girls is 111 to 100 (Prothro 1961). Here the dislike for girls is expressed openly, even to the point where there may be a lack of the acknowledgment of the birth of a girl. Not only are male children better fed but they are more likely to be taken to a doctor if ill (Williams 1968). Lack of care for girls can also be readily seen in India where
the mortality rate is 41 percent for girls as opposed to 25 percent for boys (Minturn and Hitchcock 1966).

Other indications of preferential treatment can be found in China where unwanted girls, but never boys, may be named with a derogatory term (Yang), in Japan where boys are indulged in all things but girls are the least desired and least fortunate (Embree 1939; Benedict 1946), and in India where girls are clothed less well, delivery payment for them is less, and fewer ceremonies are held for them (Minturn and Hitchcock 1966). In Japan (Embree 1939) and in Lebanon (Williams 1968) boys have preferred treatment over all girls.

Contrary to many popular theories on the oral deprivation and harsh toilet training methods believed responsible for severe emotional problems, the cultures involved in this study showed quite the contrary. Infants are nursed on demand until weaned in Northern and Southern Sudan (Barclay 1964; Deng 1972), Java (De Waal Malefijt 1963), India (Minturn and Hitchcock 1966), among the New Zealand Maoris (Honigmann 1967), Thailand (Ratanakorn 1959), China (Diamond 1969), Japan (Embree 1939), Okinawa (Maretzki and Maretzki 1966), Lebanon (Prothro 1961), Peru (Adams 1959), among the Gusii of Kenya (LeVine and LeVine 1966), among the Dusun (Williams 1969) and among the Ashanti (Lystad 1958). In addition, they are frequently nursed whenever they cry, whether hungry or not. In Lebanon this method of quieting a child is used so much that even if a child is merely restless, the breast will be pressed on him and only after repeated feedings will the mother use other means to quiet him (Williams 1968). Of the cultures considered, only among the Jivaro Indians of South America and
among the Ngoni of Nyasaland (Read 1960) will the infant go through long periods of time crying when hungry, due to the fact the mother is working and is not present to nurse the infant.

The age of weaning varies widely, ranging from the age of a few months among the New Zealand Maoris (Honigmann 1967) where it is done gradually and leniently, to 5-7 years among the Jivaro Indians, to as late as 10-12 years for the youngest child among the Javanese in Surinam (De Waal Malefijt 1963).

The methods used for weaning are much the same. The ones used in almost all cases include putting noxious substances on the nipples, sending the child to stay with relatives for a few days, and refusing the breast. In rare instances some cultures use harsher methods if these prove ineffective. Among the Japanese the child may be teased (Benedict 1946) and in Okinawa the mother may wince as if in pain or shame the child when he attempts to nurse (Maretzki and Maretzki 1966). The harshest methods are employed, when other methods fail, among the Gusii of Kenya and Dusun. Among the Gusii the child may be ignored, slapped, or his arms may be burned with a caustic plant juice (LeVine and LeVine 1966), while the Dusun will scold, shame, or push the child away. Scornful comments such as "dirty", "you will suck bowel worms", "you will suck blood", may be used or the child will be threatened with "I shall throw you away" (Adams 1959:62).

Toilet training is often a casual matter. Among the cultures studied, little or no effort will be made to toilet train, and what effort is made will be casual without punishment for lapses. Although the New Zealand Maoris start early it is done gradually and leniently, as with weaning (Honigmann 1967). Exceptions occur among the Gusii.
of Kenya where punishment for lapses is frequent (LeVine and LeVine 1966) and among the Dusun who begin training early and shame the child for lapses (Williams 1969). From this it appears that the attitude toward weaning is similar to that directed toward toilet training.

In most of these cultures the father remains distant and aloof and is rarely involved with infants. Especially harsh in this regard are the Chinese among whom the father may have no interest in the child and even seem to hate its very existence. Usually he will refuse even to touch or hold it, although he may on rare occasions play with sons (Yang 1945). Exceptions to this almost total lack of involvement may be found among the New Zealand Maoris (Honigmann 1967) and the Ngoni of Nyasaland where some fathers may show affection for infants and hold and carry them about. However, among the Ngoni this care is often quite inconsistent (Read 1960).

For the most part, infants receive much fondling and are treated with great affection and indulgence. They are carried about during most of their waking hours in the daytime by their mother or other caretakers in Thailand (Ratanakorn 1959), China (Diamond 1969), Lebanon (Williams 1968), Japan (Benedict 1946), Okinawa (Maretzki and Maretzki 1966), Java (De Waal Malefijt 1963) and in Peru (Adams 1959). Also, they are picked up and comforted whenever they cry or whimper in Okinawa, Lebanon, and in Northern Sudan (Barclay 1964).

They are indulged and treated with affection, played with, fondled, rocked, sung or hummed to, and are always under the close care and constant attention of someone in Thailand, China, Southern and Northern Sudan (Ding 1972; Barclay 1964), Lebanon, Peru, among the New Zealand...
Maoris, and in Japan where children get what they cry for (Embree 1939). In Nyasaland the infant is generally cared for by a girl in her teens while the mother works. The caretaker carries, fondles, and croons to the child, but when the mother is not present for nursing, the infant is often left to cry itself to sleep (Read 1960).

Exceptions to this quite consistent, constant and indulgent form of infant care are found in varying degrees among the Dusun, the Jivaro Indians, in Kenya and in India.

Among the Dusun the mother spends most of the first six months with the infant, carrying it everywhere she goes and playing with it. However, it is believed the infant should sleep all night and much of the day for the first eight months. If the infant wakens during the night, the mother may scold or threaten it to get it to sleep. If the infant fusses while being bathed (which is done twice a day), the mother may slap it (Williams 1969).

Among the Kenyan Gusii an infant is believed to be fragile and so every effort is made to ensure its survival. As a result it is never left alone, it sleeps with its mother, and has its needs taken care of. However, the mother does not show affection and cares for it mechanically. The most affectionate care is given by the caretakers while the mother tends to remain aloof unless something is going wrong. Frequently, even the affection of the caretakers is rough and sometimes the child is ignored so that this affection tends to be as inconsistent as that received from the parents. Mothers become annoyed with an infant who cries when not hungry or hurt and will threaten or beat it to teach it to be quiet. This, added to the punishments received during
weaning and toilet training, make the ages from 18 months to three years a period of severe punishment for the child's dependency needs (LeVine and LeVine 1966).

Among the Jivaro Indians of South Africa an infant may be left for long periods of time without receiving attention as the mother is frequently working in the fields (Harner 1972).

In India, aside from the fact the infant is fed on demand, little attention is paid to it. For the most part, the infant is placed in a cot with a quilt or sheet entirely covering it and is only cared for when he cries or fusses. As noted by (Minturn and Hitchcock 1966;111) "Adult interaction with babies is generally aimed at producing a cessation of response rather than a stimulation of it". As a result, the infant's life is bland, free of either stress or creative stimulation.

**Simple and hebephrenic categories**

Many of the child rearing practices and attitudes toward children from weaning until six to seven years of age are similar among cultures where simple and/or hebephrenic schizophrenia is more commonly found. This period emerges following the extreme indulgence of infancy, which ends at about the time of weaning. At this time, the attitude of the mother toward the child tends to become one of indifference.

The temper tantrums and rages that tend to occur during this stage are generally ignored by the Chinese (Diamond 1969), Japanese (Embree 1939), and Okinawans (Maretzki and Maretzki 1966). Among the Chinese the child who continues to be noisy and whiny will be bribed into quietness with sweets or money so that he soon learns that whining
brings reward rather than punishment (Diamond 1969). In Japan, boys are very spoiled and will get anything they cry for and demand long enough. They are allowed to strike their mother in a rage and call her a fool (Embree 1939) and pinch their sisters without fear of reprimand (Seward 1972). Children are also allowed to indulge in boasting and criticizing others (Benedict 1946). Among the Okinawans, it is felt that it is easier to give into the demands of a child than oppose them (Maretzki and Maretzki 1966); however, the demanding child may be ignored, ridiculed, shamed or punished. Adults may scream back at him and walk away, while child caretakers may leave him behind or drag him along forcibly.

The Javanese child who continues to have tantrums for an unduly long time after weaning may be sent to a relative for a time, but for the most part the child is treated with great permissiveness and given anything he wants if it is at all possible. If it is impossible to grant his wishes, this is blamed on external agents rather than the parents. They feel it is better to lie to avoid unpleasantness than to deny a request outright (De Waal Malefijt 1963). Dinka children of Southern Sudan, especially boys, are expected to learn to accept the absence of their mother without tears (Deng 1972), and the child among the Northern Sudanese, when pushed off on his own, will be told by adults to be quiet or to "beat it" when he cries for attention (Barclay 1964). In contrast to this, the Ngoni child who feels slighted or miserable can always find someone in the village to comfort him (Reed 1960).

The attitude of the Gusii of Kenya toward the crying child is one
of harshness. He may be frightened with threats, and if he is crying for "nothing," he will be severely beaten. "Most...mothers will use any device they deem effective to stop the crying of a child so that they can switch their attention to something else" (LeVine and LeVine 1966:144). If the child has been hurt, he is not likely to be comforted. "The aim is always to stop the child's crying quickly, and when he has learned to bear small hurts stoically, the mother pays no attention to them" (1966:145). However, it is felt better for a child to cry if someone else has hurt him than if he has been hurt through his own fault.

After the period of weaning is over the child is turned over to be cared for by older siblings in China (Diamond 1969), Japan (Embree 1939), North Sudan (Barclay 1964) and Kenya (LeVine and LeVine 1966). Children who have been sent to other relatives for the duration of weaning may decide to remain there in Java (De Waal Malefijt 1963) and Nyasaland (Read 1960). In Java the first born child may be left in the care of its grandparents when his parents begin their own home, and in Thailand a child may be adopted out to relatives and friends (Ratanakorn 1959).

For the most part, children in this age group tend to be left to fend for themselves and so turn to one another for support. The learning that does take place is expected to be by imitation and observation for the most part. Exceptions to this occur among the Japanese and Okinawans where active effort is made by adults to teach the child. In Japan the child learns through example and instructions endlessly repeated by the mother (Embree 1939). In both Japan and Okinawa the child is taught physical skills and polite manners by passively submitting to being placed through the motions (Benedict 1946; Maretzki...
and Maretzki 1966).

There is no crawling stage in Okinawa or Java as the child has been carried everywhere until he reaches the age of learning to walk. Crawling is also discouraged in Japan as the houses are easily damaged so that the infant is constantly admonished that certain activities are bad (Maretzki and Maretzki; De Waal Malefijt; Benedict).

In Java and North Sudan children are allowed to do about anything they please. They are allowed to sleep or eat whenever they are tired or hungry rather than having a special bedtime. Sharp implements may be left lying around and used by small children in Okinawa and Java, and even though the child may cut himself, adults make no effort to hide them (Maretzki and Maretzki; Barclay; De Waal Malefijt). Okinawan children are allowed to pilfer from gardens and attack each other without discipline. Obedience is not expected except for conformity to safety rules, and although he may be told to do certain things, he is not punished for failure to comply (Maretzki and Maretzki 1966).

Until the ages of about six or seven, children in China, Japan, Okinawa, Sudan and Nyasaland are believed incapable of learning or understanding and so are not held accountable for their actions. As a result, discipline is frequently neglected and if it occurs, it tends to be less severe than for older children. For this reason, the demands on the child are few; however, there are certain things children are trained in during this period.

For the most part, the major areas in which the children are trained are obedience, submissiveness, non-aggression, cooperation and respect for elders. In fact, in Thailand this training is so complete
that a mere facial expression is enough to curb even a toddler's behavior. As Ratanakorn states (1959:47) "...occasionally some of them are 'too well'behaved'. In Okinawa and Northern Sudan it is primarily the girls on whom the burden of docility and withdrawal is placed. In Japan, this submissiveness is primarily reserved for the son in relating to his father, not in relation to his mother (Moloney 1954).

Despite this expectation for submissiveness and non-aggression by the child among the Okinawans, beginning in infancy and continuing into childhood the adults may tease the child for amusement. They may hold their arms, thus restricting them bodily, withdraw desired objects, and pretend to scold and hit. They are amused when the infant screams and strikes out in anger and may express surprise and mock anger at this. When the child finally cries, everyone laughs and the mother slaps the aggressor. Also, the mother may tease the infant by gently slapping it and saying over and over in mock anger, "naughty child". (Maretzki and Maretzki 1966).

Among the Chinese, fighting with peers is a serious offence and the child will be punished no matter who started it. As a result, the child soon learns to report an aggressor rather than fight back. The body of a child is believed to be a gift from the parents and not the property of the child so that a child is punished if he injures himself in play. For this reason, he soon learns to play games in which there is no chance of injury.

Intense emotions of any kind are disapproved of and an individual strives for an even emotional level without showing visible emotion of any kind. Wild laughing, shouting, gossiping, boasting, and ridiculing
others is discouraged, as are open displays of rage, hatred, or strong feelings of pleasure and love. Even young children seldom cry after the age of four, and their faces show little curiosity when they watch an unusual event (Diamond 1969).

Modesty training usually begins early for girls. Boys generally receive very little and it begins much later for them. An exception to this occurs among the Ngoni of Nyasaland where both boys and girls learn to sit correctly with coverings over their genitals (Read 1960). In China and Japan this training for girls is so strict that even in sleeping the girl must learn to sleep on her side with her legs together, and she will be punished for lapses (Diamond 1969; Benedict 1946). In Okinawa, boys are allowed to tease a girl who has forgotten to sit correctly so that her genitals are exposed (Maretzki and Maretzki 1966).

Generally around the ages of six or seven the lives of boys and girls diverge even more sharply. About this time the tasks of a girl increase in number, her freedom is sharply curtailed, and she is bound close to the home to learn domestic tasks. In contrast, a boy's life still remains relatively free, or even more free. He may go to school or begin to do some tasks, but even such tasks as he may do will not keep him confined to the home or away from his peers, nor do they tend to curtail his freedom.

The inferior status of the girl now becomes even more apparent. In China girls are dominated by their brothers in play and disagreements, and in Japan they are expected to look up to their brothers and give way to them in all things, even if they are older (Yang 1945;
Moloney 1954). Here, proper respect is shown in that the wife bows to
her husband, younger brothers to older brothers, sisters to all brothers,
and all children to the father (Benedict 1941). In Okinawa the boys at
school now leave the classroom first, head the lines, and get the first
turn at equipment. It is expected by adults that the boys will bully
the girls, and they do. Although both boys and girls may act as care­
takers for younger siblings, boys are more likely to shirk their duty,
and are allowed to do so, leaving the task to the girls (Maretzki and
Maretzki 1966).

In Northern Sudan, girls of this age stand at the bottom in terms
of status in the family. Theirs is the most subordinate role of all and
they may be ordered about by older sisters, all brothers, and all elders.
The task of household chores and care of younger siblings falls on them
(Barclay 1964). Among the Dinka of Southern Sudan, although boys may
run errands and care for animals the work of boys and men is graded
according to age. This is not true for females whose work remains the
same from childhood to adulthood. All females work harder than their
male counterparts at any stage in life. The subordinate state of girls
of this age is so obvious that the word "slave" is used to characterize
a female (Deng 1972).

Punishment for children in this age group tends to become more
harsh. Punishments may be verbal or physical or a combination of the
two. The most common physical punishments used include slapping, beat­
ing and occasionally food deprivation. Verbal punishments consist of
scolding, cursing, threats, teasing, ridicule and shaming. Although
the mother is the one who most frequently does the disciplining, the
father is more feared as his punishments are frequently more severe.

The types of threats which are most commonly used are that the parents will give the child away, or that some authority figure, animal, or supernatural being will come and take the child away. Gusii children of Kenya are also threatened with being thrown out, eaten, killed or tied up in the house. (LeVine and LeVine 1966). In Okinawa a child may be subjected to sneering remarks if he fails to keep clean, being asked if the rats walked on him or being told to sleep with the rats (Maretzki and Maretzki 1966). The Javanese child is told that people will not think well of him for certain behaviors (De Waal Malifijt 1963).

Punishments, in addition to those previously mentioned, may include being ignored, and not talked to or about in China (Diamond 1969), being tied to a post of the house in Kenya and Okinawa, or tied and hung up by wrists in China (Diamond 1969), being deprived of food in Kenya and Uganda (LeVine and LeVine 1966; Lijembe 1967; Apoko 1967), and having a cone of powder (moxa) burned on the skin in Japan (Moloney 1954; Benedict 1946) and Okinawa. In Northern Sudan, adults may drive children away by throwing sticks and stones at them and yelling (Barclay). Although masturbation is allowed in Japan (Benedict) a child will be beaten for it in Kenya (LeVine et al; Lijembe), Nyasaland, and in China, where he will also be threatened with being unable to urinate and going crazy (Diamond).

Punishment tends to be inconsistent in China (Diamond 1969), Okinawa (Maretzki and Maretzki 1966), Kenya (Lijembe 1961: LeVine and LeVine 1966), Uganda (Apoko 1967), and in Northern Sudan (Barclay 1964). In Okinawa not only is punishment inconsistent and haphazard,
but praise and rewards are as well. Adults often promise things they
do not carry through on so the children learn to take promises as well
as threats with a grain of salt. Both praise and punishment refer to
the child himself rather than his action or response to the situation,
so that rather than wondering if he did a task well or poorly, the
child will wonder if he was good or bad to do it the way he did
(Maretzki and Maretzki 1966).

Although praise is extremely rare in Kenya, the parent may vacil-
late between being very harsh, ignoring the child, or responding with
indulgence, with the result that there is great inconsistency. Threats
of being thrown out in the dark and being eaten by animals if a child
cries without reason are used to make the child fear animals and stran-
gers so he will be easier to control. Fathers tend to be harsh and may
punish the mother as well, but training is inconsistent to such an ex-
tent that, as seen by Lijembe (1967:18) "...it was difficult for chil-
dren to know which was the accepted way of expressing respect towards
their parents until, as in my case, I had acted one way or another, and
had been rebuked or, less frequently, praised." Conditions in Uganda
are much the same as those that prevail in Kenya (Apoko 1967).

Among the Northern Sudanese where threats that outsiders will
come to harm the child are used, children tend to panic. Some parents
seem to take delight in the panic which this induces in the child and
often use them merely for the amusement derived from the child's re-
action (Barclay 1964).

Among the Dinka of Southern Sudan ridicule is one of the chief
forms of punishment for the child who strays into behavior of the
opposite sex. One form of insult used is to tell the child he resembles his mother; another is to refer to him by his mother's name. In contrast, to tell a child he resembles his father is to praise him highly. It is felt that for a parent to praise his child is the same as praising himself, as the two are seen as almost one, thus, praise of children takes more subtle forms, often in the form of depreciation (Deng 1972).

As children grow older and approach adolescence, they have, by and large, integrated the teachings of their culture within themselves so that the way they view themselves and the world is pretty well established.

Among the Chinese a ceremony is held at 16 years for the departure from childhood. For boys this means passing from childhood into adolescence, for girls it is passing from childhood into adulthood (Van Gennep 1960-1908-). Education is seen as a privilege, and as children grow older, they feel guilty for being allowed what they do not deserve and begin to feel an obligation to repay their parents for this privilege (Diamond 1969).

The lesson learned in school by the Japanese is on the value of cooperation rather than initiative. In contests all children are given prizes, and in academic areas all children are passed so that neither parents nor children will feel slighted or suffer psychological harm. As the male child is seen as a representative of the family, he must learn not to bring shame on it by disrespect or disobedience and so must learn restraint (Benedict 1946). Laughter and ostracism is the family's most powerful weapon to control him (Seward 1972) and
since rejection by the world has been dramatized for him so effectively in early childhood, he dreads ostracism more than violence. His fear of ridicule is so great that he will always do the traditional thing rather than risk laughter. Thus, when a young man calls on a girl, he may wrap a towel around his head to cover his face so that if she refuses his advances, they can meet another day as if the event had not taken place. Again, if a caller should arrive when the host is not properly dressed, the host will leave the room as if he had not seen the guest and will return later when the host has had an opportunity to dress properly (Embree 1939).

The Japanese girl is now restrained more in the house, has more duties, and receives fewer presents and less attention. Thus, childhood ends for girls in isolation and exclusion with no way out but marriage. As a result, they become sullen, withdrawn, and hard to teach (Benedict 1946).

The Javanese child is socialized by means which stress the danger as coming from outside sources and so learns to see his own group as a place of security and the outside world as hostile and threatening. Within the group the emphasis is on cooperation rather than individual achievement, with the result that there is strong internal group cohesion (De Waal Malefijt 1963).

It is believed by the Dinka of Southern Sudan that the individual should not harbor grievances but should rather voice and resolve them. With this in mind, children are encouraged to fight, and the courage shown in these encounters, rather than the show of strength, is valued. The child who cries from the hurts he receives will be rebuked even by
his parents. Adults are not expected to cry, although women may be 
allowed to do so in some emotional states, although not for any phys­
ical reason (Deng 1972). The learning of children among the Northern 
Sudanese "is often the learning of how to behave in a limited number 
of distinct and specific situations from which there is little gener­
alization" (Barclay 1964:227).

Among the Ngoni of Nyasaland, social ostracism is used with in­
creasing force as a penalty for nonconformity as the child grows older. 
After he reaches the age of six and one-half to seven and one-half the 
Ngoni boy begins to live in a boy's dormitory to remove him from the in­
fluence of women. Here he is subjected to harrassment by older boys so 
that he will learn cooperation with age-mates and deference to superiors. 
Under this regime he soon goes from a well-fed, spoiled, self-confident 
youngster to one that is skinny, subdued, hungry, and suffering from 
food deficiency. The daily routine of girls changes little. A friend 
is chosen for her to grow up with and to wait on her to some extent. 
Although a girl may help with some housework, generally she does only 
as much as she wishes. Although generosity and self control are stres­
sed, both boys and girls fight and quarrel frequently (Read 1960).

Among the Gussi of Kenya, assault and rape are frequent and the 
homicide rate is high. The Gusii individual is paranoid in much of his 
outlook and views his neighbors and even his family with suspicion and 
reacts to his own frustrations by accusing others of being the cause. 
As married women come from outside the community, they are enemies 
without the protection of their own families, but men are quieter, more 
withdrawn, and less sociable than the women. Children are not encouraged
to fight but rather learn to report aggression by others. Older children are responsible for younger ones and will frequently be held accountable for the latter's misdeeds or for any harm that may befall him (LeVine and LeVine 1966).

Catatonic categories

The life of young children in India centers around the courtyard with the women. It is expected that women must cover their faces with their saris and crouch before the presence of their husbands or any older male who may be present. Thus, the entire courtyard may be immobilized when a male enters (Minturn and Hitchcock 1966).

As children are not considered teachable until they are able to speak, no demands are placed on them; however, once they can talk, they are expected to obey. Since it is believed they learn best through observation and imitation, little attempt is made to explain the demands made on them or to instruct them in what is expected.

Praise or reward for good behavior are rarely used and the emphasis is rather on the use of punishment to control behavior. In addition to the types commonly used in most of the cultures studied, we also encounter behavior oriented to the loss of status and abandonment by the group, such as locking the child in a room without windows or light.

Despite the frequent use of punishment, children are not especially well-behaved. Since small children are not expected to comply and older children can escape by running out of the courtyard, the child learns how to outlast his mother's outbursts rather than to obey her. One way

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in which she shows her displeasure is by refusing to speak to the child for several hours. In fact, "...adults commonly show their displeasure by wrapping themselves in a quilt, retiring to their beds in stony silence, and fasting until someone persuades them to forget their anger" (Minturn and Hitchock 1966:124).

A good child is one who obeys, is polite, peaceable, and brave while a bad one is one who demands or is stubborn. As noted by Minturn and Hitchock (1966:134), "Since the mothers almost never clarify their expectations to the children, some of the reluctant obedience to adults may well be due to the fact that the child is not clear about what behavior is required in what circumstances."

The treatment of boys and girls diverges sharply about the time the child is five, and their care falls more to the person of the same sex. Frequently they do not perform many tasks, partly because, in the case of girls, they are considered as guests in their own homes, and in the case of boys, because men consider certain forms of manual labor as degrading for members of their caste (Minturn and Hitchock 1966). There is an emphasis on instilling a sense of belonging and responsibility to the family (Gaitonde 1964), and although the child is always a secure member of the group, he is never an important individual (Minturn and Hitchock 1966).

Among the Munda of tribal villages in Bihar, India, one of the important institutions (now dying out due to the influence of Christianity) was the youth dormitory for boys and girls. Here they were trained in social and religious duties as well as the dance. (Sachchidananda 1964,1965). The dance, as described by the Illustrated
"...is primarily an attempt at story-telling by means of highly controlled and sometimes infinitessimal movements of parts of the body" (366). The popularity of the dance may be partly explained by the fact that the spectacular display which accompanies it calls for a passive, receptive, and contemplative state of mind, which fits in well with the Indian view of life.

The population of South America is very heterogeneous, consisting of a variety of native Indian groups, blacks and caucasians (Wagley 1953). Among the Jivaro Indians who inhabit the tropical forest of the Ecuadorian and Peruvian Amazon, sexual division of labor begins early, at about four years of age. The tasks of girls include caring for younger siblings and domestic chores, while the boy begins to learn the art of hunting so that by the time he is nine he is quite skilled. Also, he may help defend the house in case of attack and will begin to accompany his father on raids somewhere between the ages of six and nine (Harner 1972).

Reasons for punishment include grabbing breakable objects, playing, or fighting over or stealing meat. Punishment may consist of spanking with a nettle, administration of a strong hallucinogenic drug, or in severe cases, hot peppers may be placed in a fire over which the child is forced to remain under a cloth until he becomes unconscious.

Children are discouraged from playing, laughing, or joking. It is felt that if they play, they will be unwilling to work, and if they laugh and joke, they will lie later in life. As houses are spaced quite a distance apart (usually one-half mile or more from
each other), children tend to be isolated from their peer group except to those who live in their own household. In addition, fathers warn them to be careful of other tribesmen who are described as deceitful and treacherous. As a result, they learn early to feel a sense of alienation from other tribesman (Harner 1972).

In Northern Brazil, among the ranchers, the lives of boys and girls are pretty similar until they reach the age of six years. Both sons and daughters work hard at a relatively early age, but at about six the boys task becomes that of watching the animals while girls begin to carry water and help with the household (Riviere 1972).

The results of this study show that, contrary to the expectations of Breen (1968), the family constellation that appears to be more closely related to the development of non-paranoid types of schizophrenia is one where little affection is shown between spouses, from father toward infant, or from parents to children past infancy. Rather, the tie that holds the family together is one of duty and respect, not affection. During childhood the main group cohesion is with age-mates. Emphasis is on learning passivity, non-aggression, and control of emotions. Throughout childhood the child learns not to ask for help but rather is left to learn on his own. The pattern of childhood that emerges is one of great indulgence and affection in infancy, indifference from the time of weaning to about six or seven, at which time a sharp division occurs between the attitude expressed towards boys and girls. Boys for the most part continue a life of comparative freedom, while girls become tied to the home with domestic chores and care of younger siblings.

Factors that appear related to the development of paranoid symp-
tomatology, and the family constellation that appears more closely related to its development, will be dealt with in the next chapter.
CHAPTER V

MENTAL DISORDERS: PARANOID

SYMPTOMATOLOGY

Paranoid Symptomatology and Isolation

From studies of the Yoruba tribe in Africa, Lambo (1955) concluded that it would be unwise to attempt to differentiate between paranoid schizophrenia, paraphrenia, and the paranoias. As he noted, even Bleuler (1924) did not think that a diagnostic differentiation was possible among the various paranoid forms. For this, and other reasons, I have studied the paranoid symptomatology as a separate and distinct entity whether it is found in conjunction with the various neuroses, manic-depressive illnesses, the schizoprophrenias, organic conditions or is found alone.

Types of disorders

The types of disorders which display paranoid symptomatology as found in the Diagnostic Manual (American Psychiatric Association 1968) include paranoid schizophrenia, paranoid states which consist of paranoia, involutional paranoid state, and other, and paranoid personality.

Paranoid schizophrenia is primarily characterized by the presence of persecutory or grandiose delusions. Hallucinations are often present and the patient may be hostile and aggressive. The paranoid states are those psychotic disorders in which the primary
pathology consists of a delusion, generally of a persecutory or grandiose type. Personality disorders are life-long patterns of behavior rather than isolated psychotic events. The paranoid personality is characterized by hypersensitivity, rigidity, unjustified suspicion, jealousy, envy, excessive self-importance, and a tendency to blame others.

**Isolation and immigration**

Isolation can take place in many ways with immigration being only one of many. But in whatever way it is produced, isolation appears to cause an increase in the occurrence of mental disorders. Eitinger (1960a) felt that the mind of an individual who is isolated remains active despite the reduction of input but that it turns inward and projects its own contents onto the environment.

A report by Faris in 1934 (cited by Hare 1952) drew attention to the fact that persons who are geographically isolated, having little contact with others, tend to become seclusive, suspicious of strangers, and avoid interaction with others. Hare also cited Sheldon's observation in 1948 that elderly persons who live alone with limited movement, while not complaining of loneliness, ill health, or unhappiness, nevertheless tend to become solitary eccentric with paranoid personalities. Hare also refers to studies reported by Line in 1951 and Fraser in 1947 on the effect of isolation in working situations. Line found that workers in the service departments of a business firm had lower rates of sickness, accidents, alcoholism, grievances, and
turnover when they had immediate access to fellow workers, with easy
access to communication and feedback on the quality of their work
performance. Fraser noted that among factory workers, there was an
excess of neuroses when social contacts were limited, while the
reverse was true when the access to social contacts was above average.

A study done by Faris and Dunham in the period of 1921-1931 on
20,000 patients in Chicago (cited by Hare) showed that the incidence
of schizophrenia was low for blacks and high for whites in black
areas, while the converse was true in white areas. It was also
found that the incidence of paranoid schizophrenia is most common in
highly mobile communities. As noted, it may be due to the fact that
high mobility results in more unmarried adults and more difficulty in
establishing long-term relationships. Other areas where isolation
may occur includes the isolation experienced by housewives, men with
strong ambitions to get ahead, students with a high degree of com-
petetiveness, and in cases of hospitalization, especially where con-
tact with family or friends is limited.

One of the reasons often cited for high or increased rates of
the mental disorders is an increase in stress, especially stress
such as that experienced as countries become more Westernized with
an increase in industrialization, or that encountered in disasters.
Pederson (1949) in commenting on the increase in mental disorders
among refugees in Sweden following the Second World War felt that the
severe trauma of the war situation had been sufficient to bring about
paranoid reactions, and that this was true regardless of the under-
lying personality structure. While it does appear that paranoid
symptomatology can indeed occur either alone or in conjunction with a number of other disorders, other studies do not appear to implicate stress as a factor in the increase of these disorders.

Langfeldt (1946) studied cases in Norway during the first three months of the war without finding any cases of schizophrenia which could be said to have been caused by the stresses of war, nor were cases with paranoid symptomatology found to have increased. Ødegård (1954), also studying the incidence of mental disorders in Norway during the war, found no increase in either the neuroses or the psychoses. His findings showed that first admissions to the hospitals decreased for both sexes and that readmissions remained unaffected.

In Helsinki, Finland, Syvänne (1952) found that although the population of Helsinki was almost doubled from a period before the war to one following World War II, the diagnosis of schizophrenia decreased from a yearly average of 155.2 cases to an average of 100.2 cases. While commenting on the fact that many minor disorders might not be hospitalized during wartime, the author noted that this was unlikely to be true of the more serious disorders such as schizophrenia.

To determine the extent to which the severity of war experiences contributed to the incidence of mental disorders, Krupinski et al (1973) studied immigrants to Australia. The various refugee groups were ranked in order of severity of experiences, from mild to severe. It was found that Jewish refugees, who had experienced the most severe stress, had the lowest prevalence rates for schizophrenia. The other groups (Polish and Russian refugees with moderately severe war experiences and refugees from the Baltic countries with mild war ex-
periences) suffered the highest rates of schizophrenia. All three groups had higher rates of mental disorders.

The Jewish refugees, with the most severe experiences and the lowest prevalence rates, had the lowest proportion living outside their immediate family settings, with only one in eleven living alone. In contrast, one in four of the Poles and Russians lived alone and one in three of the Baltic group. For all three groups it was found that a greater proportion of those with mental disorders lived alone than did non-patients. In addition, the Jewish refugees associated mainly with members of their own ethnic group, while the other refugee groups mixed frequently with native born Australians and other refugee groups as well.

Thus, it would appear that the degree of isolation from one's family, friends and ethnic group plays a larger part in the etiology of mental disorders than does stress alone. As noted by Hare (1952), the added stress which occurs during a period of war may be compensated for by the increased social cohesiveness and support which is engendered during any period of disaster. This may especially hold true for the more severe disorders. Mezey (1960a), in a study of 82 Hungarian refugees admitted to hospitals in London, found that only 21.4 percent of the schizophrenics had emigrated with a companion, while 39.1 percent of the patients with affective disorders and 31.7 percent of those suffering from neurotic and personality disorders had done so. Of the schizophrenics in this group (14 or 17.07 percent of the group) nine were paranoid, one hebephrenic, one schizo-affective, two were with paranoid states, and one with paraphrenia (Mezey 1960b).
Kino (1951) studied Polish males who arrived in England following the Second World War and who were hospitalized in the period 1948-1949. These patients suffered from acute paranoid excitement states, a type of disorder which was not found to be present in Polish patients admitted after 1949. Kino found that these patients had little or no knowledge of the English language, and that they had suffered no unusual problems while they had continued to work with their own groups. However, after being transferred to work in a foreign environment where the language and customs were unknown to them, they began to become suspicious of and mistrust their fellow workers. Unable to understand the language, conversations and remarks by their fellow workers were interpreted as being hostile to them, gradually leading to the development of the symptoms for which they were hospitalized.

One question frequently raised by workers dealing with the disorders which accompany immigration is whether the premorbid personalities of those individuals who migrate are such that those who are misfits or who are more predisposed to mental disorders will be more likely to choose immigration. However, it seems that this is not the case, when we consider groups of refugees who immigrated through no choice of their own. Copeland (1968) addressed himself to this problem of choice in a study of West African students in London. As he observed, since their purpose for being in London was to gain an education, it must be assumed that neither their premorbid personalities, nor any tendencies toward mental illness, played a part in their decision to migrate. Out of 60 students who had been hospital-
ized for mental disorders, it was found that persecutory symptoms were present in 57. Ideas of influence were found in those suffering from both the depressive and schizophrenic psychoses and there was also a high frequency of grandiose delusions in both the affective and schizophrenic groups.

Another question frequently raised is whether the country of origin has any bearing on the incidence of mental disorders as found among immigrants. However, it seems that this plays a very small role when one observes that regardless of the country from which the immigrants come or to which they go, the incidence of mental disorder is higher among them than that of the native population, or than that of their country of origin. Rather, the studies seem to indicate that the length of time that has elapsed since immigration plays a greater role in influencing the rate of disorders. Thus, individuals who have been in their adopted country long enough to be assimilated into the cultural context appear to have a lower incidence, while the greatest number of disorders occur during the early periods of assimilation.

Among the 60 West African students reported on by Copeland (1968), 19 had become ill during their first year in London, 20 in the period of one to two years, 15 between two and five years, and only five after five years. Collomb (1959) reported on a group of Africans (primarily soldiers) hospitalized in France and in French West Africa. He found that schizophrenia, mainly of the paranoid type, was the most frequent psychosis. However, he failed to differentiate between the results of those hospitalized in France and those hospitalized in Africa, and so it is not possible to draw any conclusions as to what
effect being in France may have had on the patients.

Hemsi (1967), Gordon (1965), and Tewfik and Okasha (1965) all reported on West Indian immigrants to England and Wales. Hemsi found that admissions for all disorders were higher for the immigrant population than for the natives. In addition, it was found that the immigrants had an incidence of 23.3/10,000 per annum as compared to findings in 1961 of an incidence of 3.75/10,000 per annum for West Indians who had not migrated. Of the immigrant group, 27 percent became ill at arrival or soon after, 25 percent within the first two years, and 47 percent after two years. In the group reported by Gordon, paranoid delusions and ideas were found in 48.2 percent of the patients (46.5 percent of the schizophrenics, 100 percent of those with schizophreniform illnesses, 63.3 percent of the schizoaffectives, 27.3 percent of the affective cases, 14.3 percent of those with neurotic and personality disorders, and 66.6 percent of those with acute anxiety states). Of the 124 patients reported by Tewfik and Okasha, 85 percent had an illness resembling schizophrenia. Of these, 58 percent had catatonic symptoms which included mutism, withdrawal and stupor, and 55 percent had paranoid symptoms with delusions of persecution, and ideas of reference and influence. In those patients who presented both paranoid and catatonic features the catatonic symptoms were not as pronounced.

In a study of refugee groups to Norway, Eitinger (1959, 1960a) found that the incidence of psychoses among these groups was five times as high as for a matched Norwegian population. Of the 60 refugee psychotic admitted to the hospital (42 with reactive psychoses,
14 with schizophrenia, and 4 with organic conditions), 52 suffered from paranoid symptoms while among a matched group of Norwegian psychotics, only 28 had paranoid symptoms. Somatic conversions occurred in about half of the refugee patients. Of the 14 schizophrenics found in the refugee population, 10 had become ill during the first three years. Of the reactive cases, about 40 percent became ill during the first year and about 65 percent during the first three years. In a refugee transport of individuals with a variety of disabilities, Eitinger (1960b) found 22 of the 44 adults in the group had paranoid traits. This group consisted mainly of Polish and Czechoslovak individuals with a variety of backgrounds, including concentration camp survivors, members of various armies, and members of political factions.

Ødegård (1945) and Astrup and Ødegård (1960) reported on results of Norwegian migrations. Their results showed that the incidence of mental disorders (counting first admissions to the hospital) was higher among Norwegian-born immigrants to Minnesota than among the native-born of either Minnesota or Norway. Admissions for immigrants to Norway were higher than for native-born despite the fact that the majority of these were from the neighboring country of Sweden. However, for Norwegians migrating within their own country the incidence of mental disorders was found to be lower for the most part except in those cases of migration to Oslo (the capital) where it was higher among migrants than among Osloborn. The authors felt this low rate might be partly explained by the fact that Norway's population is relatively stable, with only a minimum of migration taking place and much of this being merely
within the same county. Pederson (1949) reported on paranoid re-
actions occurring in four refugees to Sweden, two of these with a
neurotic disorder and two with psychotic conditions. From his
study of their case histories, he concluded that the difficulty in
part lies in the fact that refugees in a foreign country must find
new social contacts, new work, a new place to live and must make
new friends.

Reporting on internal migration among the Aleuts and Eskimos,
Bloom (1972, 1973) found that women are more likely to migrate
from rural areas to urban centers and villages than men, with a
corresponding higher rate of emotional disturbances among women.
In a study of hospitalized patients in Saskatchewan, Canada, Ward
(1961) found that the ethnic group to which the patient belonged
had little to do with the prevalence rate or the type of mental
disorder displayed. However, when divided between foreign born
and Canadian born patients it was found that the foreign born were
in excess of the number that could be expected. This excess was
found to be due primarily to a larger number of organic disorders
among the foreign born who were for the most part older than the
Canadian group. These immigrants had been in Canada for a long
period of time, the most recent arrivals having arrived at least
six years previously. Therefore, it might be expected that any
factors which may have been influenced by a recent arrival in a
strange country would have long ago been eliminated.

Dayton in 1940 (cited by Hare 1952) reported on admissions to
mental hospitals in Massachusetts for the period from 1917 to 1933.
where the number was highest for the foreign born, and, in decreasing order of frequency, for native born of foreign parents, native born of mixed parents, and native born of native parents. Among Spanish-speaking Puerto Ricans living in New York City, Malzberg in 1956 (cited by Tewfik and Okasha 1965) found they were twice as likely to be hospitalized as native-born New Yorkers when corrections were made for age. Out of a Puerto Rican population of about two million in Puerto Rico, about 160 patients were admitted annually to hospitals, while the annual admission rate out of a Puerto Rican population of 355,000 in New York was about 400.

Paranoid symptomatology resulting from migration also seems to be implicated in studies conducted in Australia. Litewan in 1959 (cited by Sanua 1969) found that migrants in Sydney tended to develop paranoidal states while Cade and Krupinski (1962) found higher rates of schizophrenia and depression amongst the migrants in Melbourne. Schizophrenia of the paranoid type was found to occur more frequently in female immigrants with a non-British background. The incidence of schizophrenia of people born in eastern and southern Europe was found to be seven times as high as Australian born natives. Schaechter 1962 (cited by Sanua 1969) also found a high incidence of schizophrenia of the paranoid type amongst immigrants in Melbourne.

Several workers in Hawaii have noted that the incidence of mental disorders among the various ethnic groups is correlated with the order of arrival. Wedge and Abe (1949), Hodel (1954), Schmitt (1956), Enright and Jaekle (1961), and Finney (1963) noted that the Filipinos who were the most recent arrivals had the highest rates along with
the Japanese (also among the latest arrivals), while the lowest rates were found among the Caucasians and Chinese. Hodel (1954) noted high rates of manic-depressive psychosis and paranoid conditions among the Filipinos, with paranoid conditions making up 16 percent of all their admissions to the hospital. He found a similar prevalence of paranoid conditions among the Chinese in Hawaii. Finney (1963) found that schizophrenic reaction - paranoid type - was the commonest diagnostic category for both Japanese and Filipinos in Hawaii while Enright and Jaeckle (1961) found the most frequent diagnosis of the Filipino psychotic was a paranoid state or if schizophrenic, of the paranoid type, while he found the Japanese to be of all schizophrenic types. In 1952, Wedge (cited by Carstairs 1958) found the rates of psychosis to be higher for Okinawan immigrants than any other immigrant groups in Hawaii.

Paranoid symptomatology which appears to be correlated with immigration has been reported by others also. Rin, Wu and Lin (1962) cited Tyhurst's observations of paranoid trends among displaced persons in Canada, and Rin and Lin (1962) reported on the frequent occurrence of the paranoid state found in mainlander female Chinese living in Taiwan. Tsung and Rin (1961 cited by Sanua) also noted that paranoid schizophrenia is more common among female immigrants from mainland China to Taiwan. Paranoid elements were also found in foreign students who became mentally ill while studying in the United States (Zunin and Rubin 1965 cited by Sanua).
Paranoid Symptomatology and Culture

A study of patients in Boston with a diagnosis of paranoia, paranoid state, or other paranoid disorders (Hitson and Funkenstein 1959) revealed that said patients came from settings in which the father, the dominant parent, expected obedience in all matters, from his wife as well as his children. The father was indifferent, inconsistent and frightening to the children, while the mother acted as a buffer between them. The children were not assumed to know what to do unless told and so were not expected to do or refrain from doing a thing that had not been specified, but they could be punished if they failed to do as told. Due to the inconsistency of the father, they could not predict for what actions they might be punished. As a result, the child came to see his environment as potentially harmful in that he could not control what was done to him, but instead had to learn to avoid threatening situations. His main efforts became directed against receiving harm and anger from others and so he began to deny responsibility for his actions, to project blame on others, and to justify his acts as being a response to a threatening environment.

Distribution

Among the areas or groups in which there seems to be a high rate of paranoid symptomatology among the mentally ill are Burma (Weidman and Sussex 1971), Iraq (Bazzoui and Al-Issa 1965), the Philippines, the Dyaks of Indonesia (Schmidt 1961), Haiti (Wittkower 1970), Ethiopia (Pavicevic 1966), the Caribbean (Wittkower 1970),

Weidman and Sussex noted that the world view of the Burmese had a great deal of paranoid structuring, with paranoid schizophrenia and confusional states being commonly found in their state hospitals. The Burmese have one of the highest homicide rates in the world (Hitson and Funkenstein 1959). Grewal (1959) found that the most common diagnosis for patients in a Burmese hospital was a violent form of manic-depression with hallucinations of persecution or of a sexual nature. Among the schizophrenic patients, the catatonic and simple types were rare, while the most common type was the paranoid. Symptoms included acting out of impulses, delusions of persecution, agitation, echopraxia, contra-suggestibility and stereotypy.

In Iraq, Bazzou and Al-Issa (1966) found that 85.2 percent of the patients were schizophrenic. Patients with depression have a picture which is dominated by paranoid ideas acted out physically or verbally. "The patient seldom feels responsible for his illness. He may regard it as a punishment from God or just as a bad stroke of fate. Projection of guilt and responsibility plays a very strong part in psychological processes here, in illness as well as in health" (Bazzou and Al-Issa 1966:829). Patients tend to be noisy and aggressive. Of 2000 patients, only 500 were women, but possibly because of their low status they are not as likely to get hospital care.

Paranoid patients in the Philippines tend to act out their impulses as do those in Burma and Iraq (Ventura 1964 cited by Sanua). Also, as in Burma, their homicide rate is high, with that in Manila
being eleven times as high as New York's (Sechrest 1966 cited by Sanua). In Haiti, the characteristic disorder was a paranoid type of schizophrenia often associated with delirium and catatonia (Wittkower 1970), and in the Caribbean a frequent picture was one of an acute transitory psychotic state with a sudden onset, confusion, psychomotor excitement, hallucinations and delusions of persecution. More single men than single women were found to be hospitalized in the Caribbean (Murphy and Sampath 1967 cited by Wittkower).

**Early Infancy**

Except for Puerto Rico, infants were desired in all the cultures studied for this section. In Puerto Rico while the mother does not want children, the father may be merely indifferent (Landy 1959). There is no sex preference in Burma (Bixler 1971) or in the Philippines where an equal number of each sex is preferred (Guthrie and Jacobs 1966). Since sons are needed to carry on the family name and for prestige, and since daughters leave the family at marriage, sons are preferred in Iraq (Lovejoy 1964). In Haiti (Herskovits 1964) fathers prefer daughters and mothers prefer sons, while in Puerto Rico although children are not desired, wives usually prefer daughters and fathers prefer sons, although in terms of affection the reverse is true (Landy 1959). The infant mortality rate is high in Puerto Rico (Landy), Haiti (Herskovits), the Philippines (Guthrie and Jacobs 1966), and in Burma (Bixler) although this is true of all age groups in Burma as it has the highest rate of death in the world (Nu 1958).
Nursing is on a demand basis in Haiti (Herskovits 1964), Martinique (Horowitz 1967), and Puerto Rico (Landy 1959). Weaning occurs at birth of next child in Burma (Bixler 1971), the Philippines (Nydegger and Nydegger 1966) and in Jamaica (Kerr 1963). The methods generally used for this include noxious substances put on nipples, being sent to stay with other relatives, and refusal of the breast. Toilet training is casual in Burma (Bixler), Martinique (Horowitz), Jamaica (Kerr), and the Philippines (Nydegger and Nydegger). Children in Haiti (Herskovits) and Puerto Rico (Landy) are punished for lapses.

Infancy is a time of indulgence, affection, attention, and few if any demands for most of the groups or areas. In the Philippines, the infant is never out of the mother's sight and even the father may interact with it affectionately (Nydegger and Nydegger). In Iraq and Puerto Rico, sons are more likely to receive a greater amount of handling than daughters, although in Puerto Rico, despite the amount of attention, the mothers' care for infants is rather cursory (Lovejoy 1964; Landy 1959). In Jamaica, the affection given infants is a result of the amusement value they have for adults (Kerr 1963).

Generally, children are believed to be unable to learn, think for themselves, or understand when they misbehave and so are not held responsible for their actions. They are seen as helpless, passive beings for whom things must be done and decisions made (Landy 1959; Still 1940; Nydegger and Nydegger 1966; Hitson and Funkenstein 1959).
In Burma, children who are accused of misdeeds will be defended by their parents and the blame placed on others so that to a certain extent lying, stealing and aggression are sanctioned (Hitson and Funkenstein 1959). In Puerto Rico, they are not deliberately taught anything, nor are they expected to act independently until maturity (Landy 1959). In the Philippines, the child is removed from potentially harmful situations or is placed where he will not interfere with others and the responsibility for keeping him from trouble lies with the caretaker. He is not expected to initiate even those tasks he has been told he is able to do, but is expected to ask permission before doing new tasks and to request help whenever he runs into difficulties rather than solving problems himself. Once this lesson of reliance on others is learned, it is especially noticeable whenever a new situation arises (Nydegger and Nydegger 1966). The child soon learns to please his parents by asking for help even with simple tasks. He is not taught to assume responsibility for himself but rather for others. As a general rule he is not punished for failure to comply with responsibility requests, but rather for breaches in training, or when his health is at stake, where unquestioning obedience is expected. If the child fails to live up to expectations, the burden is placed on his parents, as it is felt that good children have good parents and bad children have bad parents (Guthrie and Jacobs 1966).

As a general rule, the main expectations of children in the ages following weaning are that they be quiet, obedient, and show respect
for elders. Young children generally receive little in the way of punishment and are quite free from cares and demands. Generally they play with their age-mates.

There is more interaction between parents and their children and more affection shown by fathers in these areas or groups than is found in those studied for non-paranoid types of schizophrenia. Children are allowed to join in adult activities in Burma (Khaing 1962) and the Philippines (Guthrie and Jacobs 1966), and in the latter the adults will often join in the play of children. In Iraq, boys accompany their fathers on the daily round (Lovejoy 1964), and fathers in Puerto Rico are moderately affectionate with their children, although both parents are more indifferent to girls (Landy 1959). As a result of the interactions within the family in these cultures, the child learns to expect support and companionship from it.

Although some sexual distinctions are made between the responsibilities and behaviors expected of boys and girls, they are generally not as severe as in the groups previously studied. However, where distinctions are made, they favor the boy.

Except for Puerto Rico where physical punishments may be harsh, though infrequent, corporal punishment is seldom used and when it is, it generally consists of slapping, pinching or hitting with a stick (Nydegger and Nydegger 1966; Kerr 1963; Herskovits 1964). For the most part, verbal punishments are used and usually consist of threats of an extreme nature. These include the invocation of super-
natural beings who are believed to injure, kill or eat bad children in the Philippines (Nydegger and Nydegger 1966), to be killed, or be punished by God, the devil or hell in Jamaica (Kerr 1963), and of threats of danger from others, being hanged, eaten, killed, having testicles cut off, having face cut to pieces, and having head mashed against stones in Puerto Rico (Landy 1959). In the Philippines, teasing and threat of ostracism cause the child a great amount of anxiety.

Punishments in Puerto Rico include being made to kneel or sit without moving, having the hands tied, and being tied to the furniture. However, punishment is inconsistent so that "...the child never quite knows when to expect to be punished, nor consistently for which transgressions of familial rules and taboos. One result is that he often tries to get away with as much as he can before he is caught" (Landy 1959;166).

In Jamaica, where physical punishment is not common but "blood-curdling" threats are used instead, the child learns to react to a pattern of cruelty that does not exist in reality (Kerr 1963).

By the time children reach adolescence, the patterns of culture have been such that the individual tends to look on the world as a hostile place and to place the blame on external agents when things go wrong.

Due to the lack of privacy among the Puerto Ricans, sleeping is one of the few ways a punished child can withdraw and is frequently resorted to, especially by boys. Since the world is seen as hostile, a child away from home will be at a loss as to how to initiate action
and will cling to his elders. Since correct behavior does not produce love and incorrect behaviors bring disapproval, the individual learns to avoid punishing situations rather than seeking ways to gain approval. As a result, rather than admitting a wrong, the individual will say nothing, will hide if he is suspected, and will deny it if accused (Landy 1959).

In Jamaica, the individual feels that it is not he who has offended or done wrong; he will justify his actions on the grounds that someone has done something to him which has caused his wrongdoing or failure. The speech habits of such people include a great deal of exaggeration, especially of an emotional nature (Kerr 1963).

Among the Haitians, there is an almost obsessive concern with the state of one's health and this is generally given as a reason for why things did or did not happen (Herskovits 1964).

In Burma, where the environment is seen as hostile, even children are expected to watch and help guard the house (Hitson and Funkenstein 1959). To reinforce the view of a hostile world, mothers in the Philippines will have an outsider scold the child while the mother steps in to protect it. In the Philippines example, children, or even adults, are not expected to remain passive when upset. In fact, an adult will express his feelings to anyone within shouting distance. Although women quarrel more frequently, men are more likely to settle disputes with the bolos (Nydegger and Nydegger 1966).

Cultures in which catatonic excitement is frequently found in conjunction with some paranoid symptomatology (as delusions of persecution) and those in which paranoid schizophrenia is common with...
some aspects of catatonic symptomatology (as psychomotor excitation),
were found to have features in common. These included a heterog­
eneous mixture of races, a number of types of family constellations
with partial families being common, a preponderance of Christianity
(especially Roman Catholicism), verbal and physical punishment of a
severe and inconsistent nature, expectations of children which were
not clearly expressed but for which they might or might not be pun­
ished, little if any praise, little warmth but much hostility from
the mother, and training in viewing the outside world as a hostile
place. With this type of situation where both the world and the
family are seen as hostile, there is no place of refuge. As a re­
sult, the individual may seek to avoid harm or punishment or with­
draw from the world, but has nowhere to seek positive experiences.

Of special interest for this study is the case of Kenya where
hebephrenia, catatonic excitement, and paranoid schizophrenia have
all been reported as being rather common (Murphy et al 1963; LeVine
and LeVine 1966). As in other cultures where paranoid symptomatology
is common, in Kenya the homicide rate is high. Among the Gusii of
Kenya, strangers are viewed with suspicion and children are taught
to fear them, older children and adults are held accountable for the
misdeeds of those younger and for any harm that befalls them, and the
individual tends to react to his own frustration by blaming others
(LeVine and LeVine 1966). As in other cultures where catatonic ex­
citement is found, among the Gusii and the Luiya tribe, punishment is
harsh and inconsistent, the child does not know what is expected of
him, the mother is aloof and pays no attention to the child unless
something goes wrong, she cares for the child mechanically and without affection, and she will use almost any method to quiet a silent child so that she will not be bothered by it. As in other cultures where hebephrenia is common, the infant is under the constant care of someone and receives affection from other caretakers (LeVine and LeVine 1966; Lijembe 1967).

In contrast to the expectations of Breen (1968), the picture of the family constellation that emerges from this study of cultures in which paranoid symptomatology is frequently found, is one in which the child is not expected to know and is not held responsible for his actions. If accused by others, he is defended and the blame placed elsewhere. Life is easy going and he is not expected to learn emotional control. There is great dependency on the group, and he learns to expect support and companionship from his family. He is not expected to act on his own initiative or take responsibility for himself, but is rather expected to seek help. Especially in new situations he depends upon others. He is more likely to participate in activities with adults (or they with him) and more likely to receive affection and/or attention from his father. Sexual distinctions, while present, are not as sharply defined as in cultures where the non-paranoid types of schizophrenia are most commonly found.
CHAPTER VI

RESULTS AND DISCUSSION

Cross-cultural and cross-sexual comparisons of the data reveal trends suggesting a relationship between certain mental disorders and certain cultural practices. The relationships thus derived are as follows:

HYPOTHESIS I: When the play of children and/or child-rearing practices of each culture were examined in relation to the symptoms of the predominant or characteristic mental disorder(s) found in that culture, it was found that specific behavior(s) which were used in culturally approved ways at certain periods of time later appeared in the symptomatology considered characteristic of mental disorders in that culture.

HYPOTHESIS II: When cultures having specific types of mental disorders in common were examined, it was found that many of the play patterns and/or child-rearing patterns were similar in these cultures. When cultures manifesting different types of mental disorders were compared, it was found that while some of the broad child-rearing patterns were held in common, there were specific differences which tended to be in the direction of some of the most noticeable differences of symptomatology.

HYPOTHESIS III: When cross-sexual comparisons were made for different expectations and their relationship with different behavior between boys and girls, a strong relationship was found.

HYPOTHESIS IV: In those cases where incidence of mental dis-
orders was broken down into different rates for men and women, it was found that different symptoms were displayed by males and females.

**HYPOTHESIS V:** Although there were found to be differences in the incidence of mental disorders, and especially in the type of disorder that occurred, as well as the most prominent type of symptoms exhibited in any given disorder, it was found that situations which would appear more difficult did not necessarily result in more members of that sex being hospitalized. However, the fact of whether or not given individuals would be likely to be hospitalized depended on many more factors than just the fact of whether or not they were mentally ill.

**HYPOTHESIS VI:** It was found that individuals who were isolated from the norms of the group in which they were raised displayed a greater incidence of mental disorders than individuals who had not been so isolated.

**DISCUSSION**

**Cross-cultural and cross-sexual differences related to symptomatology**

Although care must be taken in attempting to generalize from a study of this type, it is nevertheless possible to search for indications of certain trends. These trends are in the expected directions for hypotheses I, II, III, IV and VI. The expected trend for hypothesis V was at best ambiguous due to the many factors that arose which made any objective analysis of this extremely difficult. These difficulties will be discussed presently.
In the examination of the play and/or child-rearing practices of a given culture in relation to the characteristic pathology demonstrated by patients in that culture very specific correlations were found. Thus, among the Malayans where the syndromes of latah and amok occur, it can be seen that in the lullabys and games of children, and in the dances, many of the behaviors that occur within these syndromes are found. These include the introduction of meaningless words into the lullaby, perhaps preparing the child for the feeling that words need not be used for communication, as is the case in latah. In the tickling, pinching, slapping and punching games the child may be becoming sensitized to these as stimuli of the type that produce such a strong reaction in the latah victim. The marriage dance of the young girls also gives the girl practice in being put into a trance, mimicking back the words that are said to her, and attaining amnesia for the event. The majority of these are the games of childhood, at the age when both boys and girls join in, with the result that both are introduced to these patterns of behavior which are also found in latah. A similar case might be made for the nursery rhymes and the dance of the Burmese.

The games of suggestion are different in that they are played only by the boys. In these games the boy is gaining practice of going into a hypnotic-like state with a loss of his awareness of himself as a person. He also learns the suggested behavior of an animal, to the extent that he becomes unaware of danger to himself, and might injure himself by the chances he takes, as in amok. Again, as in amok, within the pattern of the game, in this state he prac-
tices chasing the other children. In the religious dance of the men he again gains practice in going into trance-like states to the extent that he becomes unaware of injuries to himself.

In the case of piblokto as it occurs among the Eskimo, details as to the games of children are lacking and so it cannot be stated whether any of the behaviors expressed in this syndrome are practiced in a play situation. However, in the daily living rituals we find the practice of being near-nude while indoors, the admonition to the child to undress quickly lest harm should come to him, the pattern of rolling in the snow, as well as the glossolalia and bizarre behavior that accompany the magico-religious rites.

Windigo psychosis among the Cree, the Ojibwa and the Saulteaux offers several interpretations. Not only is starvation a very real threat, but among the Ojibwa, especially, the child is made to experience the reality of hunger at a very early age in the fasting that he must undergo. The games of the Cree and the Ojibwa contain plentiful examples of enemy attacks and the flight from the cannibal, and the folklore of the people regularly provides the children with accounts of such events. It must also be kept in mind that the disorder is not experienced by females unless they have been raised in the same way as the boys and so have shared the same types of experiences.

Again, among the Chinese, knowledge of the games of children is lacking. However, the threats to the child for loss of semen are known. The child is betrothed early and holds a responsibility to his betrothed from an early age, with the result that responsibility
for sexual abstinence is a reality for him from an early age, as well as threats to his health and loss of vital essence if he should stray. From these data, it can be seen that specific, culturally approved behavior can and does affect the type of mental disorder and/or symptomatology that occur within a culture. Also, it can be seen that whether only one sex experiences certain cultural practices or whether both sexes do, will have a bearing on whether the mental disorder or symptom patterns will occur in only one or in both sexes. Furthermore, for these culture-bound reactive syndromes, cultures which have these features in common will display similar types of disorders and/or symptoms.

The two cultures chosen for the study of the symptomatology of simple schizophrenia were from Thailand and China. The predominant religion of both of these cultures is Buddhism, with emphasis on the practice of withdrawing from the world to a life of meditation and on the inferiority of females. Sons are desired rather than daughters, and the primary relationships are male-oriented. Although the children are shown a great deal of affection and indulgence when infants, especially boys, the attitude of the parents toward them after they have been weaned is one of indifference.

As to specific behaviors exhibited toward the children which correlate closely with those found in persons suffering from simple schizophrenia, there is the submissiveness and nonaggression which is thoroughly drilled into the child. Among the Chinese, children are taught that their bodies are not their exclusive property but
are gifts from their parents. This results in an estrangement from the body and fear of activities that might result in any form of injury. Children may be ignored or they may be bribed into being quiet. Thus, the manner of discipline is somewhat inconsistent. Interactions between children and parents is almost absent except in punishment situations, as the adults rarely talk to, play with, or sing to children. Thus, children learn not to turn to adults. Intense emotions of any kind, whether of a positive or negative nature, are frowned on, and this training is so strict that even young children seldom cry or show any curiosity at new situations or events. Within the context of these behaviors can be seen some of those experienced in simple schizophrenics. This is the apathy, withdrawal, the indifference and the adjustment of the patient to a low level of functioning.

The cultures in which the hebephrenic type of schizophrenia was more commonly found included groups in Japan, Okinawa, Java and the Sudan. Religions which are predominant include Shintoism, Buddhism and Confucianism among the Japanese and indigenous beliefs which have been influenced by Buddhism and Confucianism among the Okinawans. Both the Sudanese and Javanese follow the doctrines of the Islamic religion, with some indigenous beliefs still being held syncretically by the Sundanese. In all of these, the female is held to be inferior to the male, and in all except the Javanese, sons are preferred over daughters.

During infancy, children, especially sons, are carried everywhere, are picked up and fondled whenever they cry, and are nursed at the
slightest whimper. Children, especially boys, are very spoiled and will be given whatever they demand. Among the Japanese this may become extreme, with a young boy able to strike his sisters and his mother with little fear of reprimand. Due to the practice of carrying children everywhere, there is no crawling stage for either the Okinawans or the Javanese, and creeping for the Japanese children is accompanied by constant admonitions due to the fragility of the houses.

Both the Japanese and Okinawan infants begin to receive training in proper etiquette while still being carried, by passively submitting to being placed in the proper positions and being put through the proper motions. It is possible that this passive submission of body movements to outsiders may play a part in feelings of depersonalization and estrangement of the body which are so frequently experienced by schizophrenics.

Weaning, which usually takes place with the birth of the next child, usually results in changes in the attitudes of those living with the weaned child. Thus, the Japanese child may be turned over to an older sibling who will ignore his cries. If this is not effective, harsher measures may be used. Among the Okinawans, this may take the form of ridicule, derisive comments, shaming and punishing, and adults may scream at the child and walk away. Among the Northern Sudanese, the weaned child is pushed off on his own to play with his peer group, and if he cries, he is told to keep quiet or "beat it".

Among specific behaviors which occur in the adult's interaction
with the children and which seem to have a close correlation with certain behaviors in persons suffering from hebephrenic schizophrenia, there is the inconsistency of behavior of adults toward the children. Thus, while the Japanese boy is allowed to attack and strike out at his mother, he must be submissive to his father. The weapon that is most effective in bringing the child into line is that of laughter and ostracism, with the admonition that "The world will laugh at you." The fear of ridicule becomes so strong that he will engage in behavior which appears to be bizarre and incongruous (wrapping a towel around his head when going courting and ignoring guests whenever inappropriately dressed) rather than face the embarrassment of laughter.

In this type of behavior may be laid down the roots for the development of the inappropriate and bizarre behavior of the hebephrenic. In the use of laughter as a means of ridicule rather than as an expression of joy or delight may be found the beginnings of the inappropriate affect and the silly giggling of the hebephrenic. And in the passive submission to body movements carried out by others may perhaps be the seed for the development of the mannerisms and posturing of the hebephrenic.

Among the Okinawans, laughter, ridicule and teasing are also used as negative sanctions with the child. In addition, during infancy and early childhood adults delight in teasing a child until he strikes out in anger, at which the adults express mock anger. Another form of teasing the infant consists of the mother gently slapping him and saying over and over again in mock anger, "naughty
Here, as with the Japanese child, inappropriate emotions are being expressed in inappropriate contexts for the child. Thus, the child is presented with laughter in a painful situation and under painful circumstances and is presented with "mock" anger in a situation which should be one of fun. In addition, both rewards and punishments are often promised or threatened without the mother following through on them, so that the child learns to disregard these statements. In this way, he is rapidly learning that the events of the world that are controlled by others cannot be controlled, or influenced, by him.

Among the Northern Sudanese, it is felt that a parent praising a child is in a sense praising himself, as the identities of child and parent are seen as very close. Thus, praise of a child takes the form of depreciation. Here, too, the child then learns that the words expressed and the emotions underlying them are not congruent. This split between the emotion and the intellect is one of the main characteristics of schizophrenia. In fact, it is the aspect of the disorder that gave it its name (split mind). Much of what is learned by the Sudanese child "is often the learning of how to behave in a limited number of distinct and specific situations from which there is little generalization" (Barclay 1964:227). This, too, appears to be a phenomenon encountered in schizophrenic patients in that they appear to lack or be deficient in the ability to generalize from one experience to another in many instances. Parents may also use threats with the child merely so they can take delight in and laugh at the panic which this arouses in the child. Again, there is laughter in a
situation which is painful for the child.

The Javanese child is also not free from this incongruity between what is spoken and what is the actual situation. He is given whatever he wants if it is at all possible, but if a parent is unable to grant his request, he will blame it on outside agents rather than his own inability to comply. It is felt that it is better to lie than to come out with an outright denial of the request.

The area in which the withdrawn type of catatonic schizophrenia is most commonly found in our sample is India. The predominant forms of religion are Islam and Hinduism, both of which tend to restrict females to inferior positions. Boys are preferred over girls. The Muslim influence results in the seclusion of women while the Hindu doctrine holds that the daily round of living is unreal and the meaning of existence is to be found in the renunciation of the world (Minturn and Hitchcock 1966).

Infants are fed on demand, primarily to keep them quiet, but aside from that, little attention is given them. As noted by Minturn and Hitchcock (1966), adults interact with infants to quiet them rather than to stimulate them. In fact, as a general rule the infant is placed on a cot with a sheet or covering thrown over him and is only tended to if he makes a fuss. Although children may be asked to do things by the mother, they are not really expected to comply with her wishes so that, despite the frequent use of punishment, children are not very obedient but instead will learn to outlast the mother's outbursts of anger. This was especially easy where purdah was practiced, since older children could run out of the courtyard where
their mother could not follow. Minturn and Hitchcock (1966) feel that one of the reasons that children are so reluctant to comply with parental wishes is that the mother fails to make it clear to the child what is expected so that the child may be unclear about what behavior is appropriate or required in a given circumstance. If the mother is especially disturbed with the child, she will refuse to speak to him. In fact, many adults when displeased will go to bed, wrap themselves in a quilt, and refuse to speak or eat until they are talked out of their anger.

Here, we find many of the behaviors which are displayed by catatonic patients: Negativism or refusal to carry out commands (or doing the opposite of what is requested), confusion as to what behavior is appropriate in a given situation, withdrawal, mutism and refusal to eat. From this it appears that the Indian child has many opportunities to learn catatonic-like behaviors.

The data on the Jivaro and the Brazilians was too meager to result in firm conclusions; however the Jivaro, like the East Indians, tend to view this world as not the real one, turning instead to a more mystical or supernatural world for their reality. Also among the Jivaro the child might be ignored for long periods of time, while their mothers worked, and their sense of isolation was heightened by the reality of their lives. Among both the Jivaro and the Brazilians in general, children worked hard from an early age and so had little opportunity to play.

In comparing results from the data on the incidence of mental disorders on people separated from the norms of the group in which
they had been raised, it was found that when this occurs, there is an increase in the rates of mental disorder, especially of the paranoid type. Factors such as severity of stress, country of origin, or of destination, or premorbid personalities seemed to play little if any part in the noted increase. Rather, it appeared that the most significant factors were the individual's access to family, friend, or ethnic group, and the amount of time the individual had been in the adopted country.

Among the cultures studied which showed a preponderance of paranoid disorders, the predominant religions are Buddhism, Islam and Christianity. Among the Philippine peoples and the Burmese, both male and female children are desired; however, boys are preferred over girls in Iraq. The fathers appear to pay more attention to their children, especially their sons, than was true of the cultures studied for the other types of disorders. Infants are treated affectionately, with no pressure put on them for assuming responsibilities. In fact, it is felt that they are not responsible and so they are taught to turn to others for help rather than to try to solve problems by themselves. If a child is accused of something, he is defended and the blame will be placed elsewhere. From this, it appears that the child learns to expect others to shoulder the blame for what he does and to expect someone to come to his assistance when he finds himself in a situation with which he is unfamiliar and where he is encountering a problem. Since he was not considered responsible for controlling many of his impulses for acting out, then he had no reason to learn aggression controls.
Variables affecting treatment

Some of the variables that might tend to affect the rate of admissions to hospitals are the extent to which individuals may be cared for at home and the extent to which differential treatment is provided to the two sexes, resulting in either a discrepancy in the ration between the two in the population at large or a difference in the treatment likely to be received when ill.

Mentally ill individuals are likely to be cared for at home, usually locked up or chained during disturbed periods, in Thailand (Thompson 1941), China (Diamond 1969), Okinawa (Maretzki and Maretzki 1966), Puerto Rico (Landy 1959), and in India (Rao 1966; Gaitonde 1964; Fuchs 1964). In India, low caste groups and untouchables are numerically very strong among Hindus, but they have one of the lowest rates of admission to mental hospitals (Hoenig and Sreenivasan 1959). This may be explained by the fact that mentally ill or retarded children may not be allowed to grow up, and mentally ill adults may be cared for at home (Fuchs 1964).

In this study, males were found to outnumber females in the hospitals in China, India, Lebanon, Iraq, Kenya and among the Maori of New Zealand. Due to the practice of infanticide and neglect of female infants, males outnumber females in the populations of China, India and Lebanon. Because of the inferior status of females, they are less likely to receive hospital care when ill in China, India, Lebanon, Iraq and Japan. Thus, in almost all cases where males outnumber females in the hospitals, it is possibly due to population
discrepancies and lack of care for females. More female than male patients are found in the hospitals in Okinawa, Japan, Java and the Sudan. These finds would tend to support the hypothesis that females who receive less attention, harsher treatment, less care, less freedom, more restrictions, and more duties from an earlier age are more likely to become disturbed, although no definite conclusions can be drawn.
CHAPTER VII

SUMMARY

In this study I have conducted a review of the literature for studies dealing with mental disorders as found in various cultures. The mental disorders which were predominantly found in or which were considered characteristic of a given group or area were then compared with the child-rearing practices and play of children to determine if any correlations existed between these two. The mental disorders were studied in three broad categories; the culture-bound reactive syndromes, the schizophrenias, and paranoid symptomatology.

Among the culture-bound reactive syndromes a correlation was found between the types of play used by children and the types of behavior found in the mental disorders when they occurred. Children of one sex who were not exposed to certain types of play did not later develop the types of mental disorders in which the behaviors of the play and mental disorders were similar. Thus, the games played by the Malay children which had behaviors which were later found to occur in amok were played only by the boys, and only men were found to suffer from this disorder. Among the Ojibwa, only males suffered from Windigo psychoses unless a girl had been raised in the same manner as a boy.

The types of schizophrenia considered in this study were the simple, hebephrenic, and the catatonic types. Those cultures where the simple and the hebephrenic types were found to be predominant,
had a certain underlying type of child-rearing pattern. These included great affection and a great amount of carrying, handling, and fondling of the infants (especially boys), with little attention paid to socialization techniques until the child was weaned. This was usually accomplished by putting bitter substances on the breast and sending the child to stay with other relatives during the weaning period. Following the weaning period, the children were treated with indifference except in instances of punishment.

In those cultures where the simple type was predominant, the main emphasis was that the individual was expected to remain impassive in the face of all types of situations which might ordinarily be expected to produce hate, anger, fear, curiosity, joy, love, and any other intense emotion.

In those cultures where the predominant type of schizophrenia was hebephrenia, the children were taught the proper actions by passively submitting to movements imposed upon them by adults. The emotions displayed to them by others were inconsistent, such as anger in happy situations and laughing used as a form of ridicule rather than an expression of joy. Due to the use of laughter as a form of ridicule, the individual would resort to "bizarre" behavior rather than allow himself to become the object of ridicule.

In the cultures where catatonic forms of schizophrenia were found, the children, from birth, were treated to indifference. There was little stress in their life, but also there was little stimulation. Although they were requested to do certain things, they were not expected to comply and were not necessarily punished.
for not complying. Rather, punishment was inconsistent, so that it was better for the child to learn to stay out of the way of the mother until she had gotten over her anger. Rewards were rarely used for the child. The child was exposed to various forms of withdrawal almost from birth, first, by being covered and isolated in a cot most of the day while an infant, and later, by observing the adults about him displaying their displeasure by withdrawing, covering themselves with a cloth, remaining mute, and refusing to eat. Requests were made in such a way that the child was often in doubt as to just what was expected of him. This, combined with the inconsistency of punishment, made it difficult for the child to know the expected way to behave.

The background of those cultures where paranoid symptomatology occurred was somewhat different from any of the above. For one thing, paranoid symptomatology of some type appears to occur commonly among individuals who are isolated from the group norms in which they have been raised. Thus, in situations of immigration it is one of the most consistent types of disorders to occur. Several cultures were found in which paranoid symptomatology was predominant. Here too, the early years of infancy are without stress. Children are indulged and are not punished. This lack of punishment which, for the most part, continues even as the child grows older, results from the conviction that children are not responsible for their actions. Rather, if they are accused of wrongdoing they will be excused and the blame will be put on others. Also, they are taught to look to adults to help them when they encounter any difficulty
in solving a problem. As a result, they fail to learn any initiative in solving problems when they find themselves in a new situation. Due to their lack of responsibility, they are not expected to be able to control or inhibit their emotional expression. People who would have a background of this type would certainly find it difficult to solve the many problems encountered in an immigrant situation, and with no one to turn to would find it easier to cast the blame on their new surroundings and new acquaintances than to look for the reason within themselves.

Since this study was not designed to determine why a given individual might become mentally ill, an effort has been made to determine how any individual might learn the behavior displayed by the mentally ill in a particular cultural context. Factors which do not seem to determine the types of behaviors that occur are the types of household, the major religion except in areas where religions treat the female as an inferior person and thus cause different behaviors to be applied to males and females, severity of stress, and stress involved in the socialization processes such as those mentioned by Freud as occurring during the oral, anal and genital stages.

Factors that do seem to play a part in the determination of the type of mental disorder that is most likely to occur include such factors as behaviors used by and toward young children, expectations of young children (or lack of them), isolation from the group, consistency or inconsistency of punishment and/or rewards for given behaviors, training in the use generalization from specific situations to new situations, and relationships among the family and the peer
group.

Thus, this study rather clearly indicates that cultural practices do have a large part to play in the type of symptomatology that occurs in mental disorders.
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