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AGEM 1970–2010: 40 Jahre Forschen im „Interdisziplinären Arbeitsfeld Ethnologie & Medizin". Rückblick und Ausblicke I

VWB

Zum Titelbild/Cover pictures 33(2010)1+2: Mensch und Tier / Man and Animal:

„Mensch und Tier" ist eines der Themen dieses Heftes. Das Titelbild zeigt zwei Abbildungen aus Katesa Schlosser 2009. *Madelas Tierleben. Tiere in Zauberei und Alltag bei Zulu und Tonga*. Zeichnungen des Blitzzauberers Laduma Madela. Kiel: Museum für Völkerkunde der Universität, ISBN 978-3-928794-54-X, 336 S., zusammengestellt von der im 90. Lebensjahr stehenden weiterhin ehrenamtlich wirkenden Kuratorin, 2. erweiterte Aufl., mit Farbbildern (with captions in English), 1. Aufl. 1992.

Links: Abb. 50, S. 141: Das Erdferkel (*Orycteropus afer*): „Das Erdferkel" ist ein Tier, das ein Loch in die Erde hineingräbt. Es geht nachts aus, um kleine Tiere zu fressen. Es frisst auch Erde. Es ist auch ein Tier der Schwarzzauberer. Sie schicken Erdferkel, um die Leiche eines Menschen aus dem Grab herauszuholen, den sie dann zu einem *umkhovu* oder *isiyingli* machen. Wenn dieses Tier dich ansieht, geschieht dir ein Unglück oder Du wirst krank, bis Du von einem Medizinmann geheilt wirst (Madelas Text). (The aardfark or antbear has four toes at the forefeet and five toes at the hind feet. Black-magicians do make use of it. They as well as aardfarks are active during the night. Caption text).

Rechts: Abb. 43 I, S. 125: Gepard—Cheetah (In olden times it was the king's privilege to make use of the cheetah's beautiful skin.—When the cheetah fights with the leopard the cheetah is on top of the leopard at the beginning, and then below the leopard. The situation changes continually until both of them get tired. When this animal is eaten, together with an ox, there is much singing and dancing. Caption text).
(Wiedergabe mit freundlicher Genehmigung der Autorin)

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Ekkehard Schröder (auch V.i.S.d.P.) mit

Herausgeberteam / Editorial Board Vol. 33(2010) - 35(2012):
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Geschäftsadresse / office AGEM: AGEM-Curare
c/o E. Schröder, Spindelstr. 3, 14482 Potsdam, Germany
e-mail: ee.schroeder@t-online.de, Fax: +49-[0]331-704 46 82
www.agem-ethnomedizin.de

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Die Herausgeber befürchten hier eher Missverständnisse oder zumindest Anlass zum Zweifeln (S. XIII), ohne sie aber klar zu benennen, und **stellen eine Analogie zur „Ethnomedizin“, wörtlich „Volksheilkunde“ als Sujet der Ethnologie her. Sie meinen: „Dagegen wird sie [die Ethnomedizin] sich** der ihr neuerdings zugewiesenen Funktion als Oberbegriff für so gut wie alle mit Gesundheit und Krankheit zusammenhängende Erscheinungen außerhalb der in den Industriegesellschaften etablierten Medizin wohl auf längere Zeit **nicht wirklich sicher fühlen** können“, wobei die Herausgeber sich auf die *Einführung in die Ethnomedizin* von PFLEIDERER & LUDWIG (1978) beziehen.

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Culture—"Pathoplastic" or "Pathogenic"? A Key Question of Comparative Psychiatry

Wolfgang G. Jilek

Abstract A key question of comparative psychiatry is whether the role of cultural factors is pathogenic (causing pathology) or pathoplastic (shaping pathology). The author presents examples of pathogenic influence of culture. Socio-cultural factors possibly accounting for the demonstrated differences in the course of schizophrenia in Western and non-Western societies are discussed. Specific pathogenic factors associated with rapid socio-cultural change, affecting North American Indian and African populations, are identified; the resulting typical psychopathological conditions are sketched: anomic depression in Amerindians, transient psychotic reactions (bouffée delirante) in Africans. Witchcraft and sorcery beliefs often characterize the picture of "hysterical" psychoses in marginal Africans and transplanted South Europeans of tradition-directed background. The author reviews "culture-bound syndromes" and the attempts at classifying them according to psychiatric nomenclature. He cites examples of the emergence, metamorphosis and epidemic spreading of "culture bound syndromes" under changing socio-economic, cultural, and politico-historical conditions. Ritualized possession and trance states, as well as religious rituals in general, are to be separated from psychopathological phenomena in order to avoid euro-centric and positivistic fallacies in psychiatric diagnosis.

Keywords cultural factors in psychiatric diagnosis – pathogenesis and culture – anomic depression – culture bound syndromes – psychosis and rapid cultural change – trance states – comparative psychiatry – Amerindians

Ist die Kultur „pathoplastisch" oder „pathogenetisch" – eine Kardinalfrage in der vergleichenden Psychiatrie

Zusammenfassung Eine Kardinalfrage der vergleichenden Psychiatric ist, ob kulturelle Faktoren eine pathogene (die Krankheit verursachende) oder pathoplastische (die Krankheitssymptome formende) Rolle spielen. Anhand von Beispielen belegt der Autor einen pathogenen Einfluss der Kultur in bestimmten Fäl1en. Er diskutiert soziokulturelle Faktoren, die möglicherweise für die nachgewiesenen Unterschiede in der Verlaufsform der Schizophrenie in westlichen und nicht-westlichen Gesellschaften verantwortlich sind. Er identifiziert spezifische pathogene Faktoren, die sich mit raschem Kulturwandel einstellen und in nordamerikanischen Indianergruppen sowie afrikanischen Bevölkerungen wirksam werden; die daraus resultierenden typischen psychopathologischen Zustände werden skizziert: Anomische Depression bei Indianern, psychotische Durchgangsreaktionen (bouffée delirante) bei Afrikanern. Vorstellungen von Verhexungen und Zauberei charakterisieren oft das klinische Bild der „hysterischen" Psychosen bei marginalisierten Afrikanern und bei umgesiedelten Süd-Europäern mit traditionsbestimmtem Herkommen. Es werden die „kulturgebundenen Syndrome" und die Versuche, sie entsprechend psychiatrischer Nomenklatur zu klassifizieren, besprochen und Beispiele für das Entstehen, die Metamorphose und die epidemische Ausbreitung von „kulturgebundenen Syndromen" unter veränderten sozioökonomischen, kulturellen und politisch-historischen Bedingungen angeführt. Ritualisierte Besessenheits- und Trancezustande, wie religiöse Riten im allgemeinen, müssen von psychopathologischen Phänomenen klar differenziert werden, um in der psychiatrischen Diagnostik eurozentrische und positivistische Fehlschlüsse zu vermeiden.

Schlagwörter Kulturelle Faktoren in der psychiatrischen Diagnose – Pathogenese und Kultur – Anomische Depression – kulturgebundenes Syndrom – Psychose und rascher Kulturwandel – Trance – vergleichende Psychiatrie – indianische Ethnien

Comparative psychiatry ("vergleichende Psychiatrie") is a term introduced by Kraepelin (1904) in his report on the nosological investigations he conducted at Buitenzorg Mental Hospital, Java, a study in which he compared psychiatric symptom formation in Indonesian patients with that of psychiatric hospital populations in Germany. As redefined by Yap (1974), comparative psychiatry studies the influence of social and cultural variables on the etiology, manifestation, evolution and final outcome of mental illness. In

this paper we shall focus on the influence of cultural variables. The term culture was first defined in scientific literature by Tylor 1871 in his famous treatise *Primitive Culture,* as "that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society". This is still the most useful and comprehensive definition; in essence it describes culture as the human-made environment, in contrast to the natural environment of man. In our use of the term, culture subsumes a system of specific norms, values and ideas which man as the member of a particular society has accepted as valid for himself and for others. The system of behavioral, attitudinal and conceptual norms differs from culture to culture, and it is these differences that cross-cultural comparison of "normal" and "abnormal" states of mind has to take into account. Carlos A. Beguin's (1952) dictum "on est fou par rapport à une société donnée", expresses a radical view of cultural relativism in psychopathology which appears to deny the existence of universal standards. There are, however, mental conditions the abnormality character of which is recognized across cultures, such as idiocy, dementia, agitated delirium, all that was called "total insanity" in ancient psychiatry (Ellenberger 1960). Nevertheless there can be little doubt that in the great majority of psychiatric conditions cultural factors play an important rôle. The question is, whether that rôle is *pathogenic,* i.e. causing pathology, or *pathoplastic,* i.e. shaping pathology; a question which has to be considered for each clinical manifestation. The prevailing view in comparative psychiatry has always been that cultural factors have pathoplastic rather than pathogenic effects. It may be of interest therefore, to mention from our own experience some examples of unequivocally pathogenic influence of culture.

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

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

(3) Culturally conditioned dietary habits may lead to neuropsychiatric pathology through mineral or vitamin deficiencies. Thus *pibloktoq* among the polar Eskimos is caused by culturally conditioned diet preferences (pathogenic effect) but its symptom formation is shaped by social learning (pathoplastic effect).

(4) Culturally or subculturally sanctioned use and abuse of noxious substances such as alcohol, narcotics, and psychedelics, exerts both psychopathogenic and psychopathoplastic effects. Culturally sanctioned abstinence, on the other hand, is the main factor in the prevention of al-coholassociated mental conditions.

Cultural factors inherent in modern Western society have been held responsible for schizophrenia by Devereux and his school of psychoanalytic ethnopsychiatry. In a recent work Devereux (1980) repeats his view of schizophrenia as an "ethnic psychosis" characteristic of modern Western society. He sees schizophrenic thinking and behaviour as "taught" and "inculcated" by modern civilization. Devereux's claim that "true" (process) schizophrenia has never been encountered in primitive populations not yet subjected to westernizing acculturation has been refuted by field observations of experienced clinicians; so among Australian aborigines by Cawte (1965) and among isolated tribal population in East Africa by Jilek-Aall (1964). However, chronic process schizophrenia appears to be less prevalent in tradition-directed societies without westernizing culture change (cf. Rin & Tsung-Yi Lin 1962—aboriginal Formosans; Burton-Bradley 1979—primitive villagers in Papua New Guinea). Socio-cultural factors exert their influence mainly on the symptomatology and course of schizophrenia. The results of several cross-cultural inquiries point to a considerable variation in the frequency of certain types of hallucinations and delusions, of catatonic symptoms and affective responses according to culture area, predominant religion, degree of urbanization and industrialization (cf. the surveys by Wittkower, Murphy, Fried & Ellenberger 1960; Murphy, Wittkower, Fried & Ellenberger 1963; Pfeiffer 1971a; Rogan, Dunham & Sullivan 1973). Clinicians working among tribal populations of development countries have for a long time reported observations indicating that the long-term prognosis of schizophrenic psychoses is overall better than in the Western industrialized world, and

that there is less tendency of progressing in chronic courses toward deterioration. These clinical impressions have since been confirmed for the indigenous population of Mauritius by Murphy & Ramann (1971) who in their twelve year follow-up study of mental hospital patients found that schizophrenic psychoses ran a less chronic course in Africans and Asians than in Europeans. On a global scale, the international follow-up study of schizophrenia conducted by the World Health Organization (1979) found that in the developing countries significantly more of the schizophrenic probands improved than in the developed countries. There is as yet no conclusive explanation for these epidemiological findings. On the basis of our experience with transient psychoses in Africa we suggested in 1970, that a chronic course might be averted if the community responds to the initial psychotic episode by sympathetic acceptance, benevolently protective attention and assistance in a culturally prescribed way, as is the case in many tradition-directed small scale societies. Conversely, Western societies have developed response patterns vis-a-vis the phenomena of acute psychosis which consist of the patient's covert or overt rejection by those around him, leading to his social isolation and stigmatization, and to the expectation that he remains in an incompetent sick role. It is these response patterns that appear to favour chronicity. Murphy & Raman (1971: 496) hypothesized in their Mauritius study that the Western patient "may be trapped within an established sick-role by the superficial rationality of his society's view of his sickness, whereas the Mauritian patient, with a range of what one would call superstitious explanations for his initial disorder, may more easily find a way of escape".

Of great relevance among the socio-cultural factors impinging on mental health are *culture change* situations which have been found to generate psychopathology specifically in the case of imposed rapid Westernization of small scale non-Western societies (cf. review of research by H.B.M. Murphy 1959). I have in previous studies (Jilek 1974) tried to determine the significant pathogenic factors which are operant in rapid socio-cultural change situations affecting North American Indians. In this instance pathogenic effects derived from: (1) *anomie* (Durkheim 1897), the loss of norms which guide individual conduct; (2) *relative deprivation* (Aberle 1966) , defined as a negative discrepancy between expectations and actuality in terms of socio-economic and legal-political status; (3) *cultural confusion* (Leighton *et al*. 1963). Cultural confusion ensues when in close contact with a technologically superior culture, indigenous people are confronted with contrasting and contradictory values and are unable to integrate the two different sets of norms.

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

In Africa socio-cultural change under westernizing* influences is characterized by rapid transformation of traditionally grown communalistic tribal groups of the *Gemeinschaft*-type organization into mass societies of the *Gesellschaft*-type. Psychosocial concomitants of this transformation are *anomie* and cultural identity confusion. These are generated by—(1) the impersonalization of social relationships, (2) ambivalence conflicts when imported Western values, regarded as alien and linked to a colonial past, are at the same time aspired to while the venerated traditional norms are no longer accepted as universal guiding principles; (3) the widening gap between the now "legitimized" individual aspirations and the impossibility for the masses ever to reach these widely emphasized goals.

This process of rapid cultural change is reflected in an increase of psycho-pathological states which in Africa, today as in the past, are often attributed to

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

witchcraft or sorcery. It is therefore not surprising that a review of available reports from sub-Saharan Africa revealed a trend toward re-activation and intensification of magic beliefs and practices, including anti-witchcraft movements (Jilek 1967). The most typical clinical condition encountered in this context is the transient psychotic or psychosis-like reaction labeled *bouffée délirante* in francophone psychiatry. Collomb (1956, 1965b) and his colleagues in West Africa considered this to be the characteristic syndrome of contemporary African psychiatry. They described *bouffée délirante* as transient reactive psychotic state, with intense anxiety, confusional elements, floating paranoid delusions, visual and auditory hallucinations; of sudden onset and of brief duration; ending with spontaneous and complete remission, followed by systematic disavowal of the often embarrassing and dangerous behaviour. Identical conditions have been recorded in anglophone Africa under diagnoses such as transient psychotic confused state, primitive confusional psychosis, acute paranoid state, fear psychosis, reactive psychosis (cf. overview by Jilek & Jilek-Aall 1970). Paradigmatic are Lambo's (1956, 1960, 1962) descriptions of conditions for which he used the terms *malignant anxiety* and *frenzied anxiety:* acute anxiety reactions resembling hysterical twilight states, with paranoid features centered on delusions of bewitchment. *Frenzied anxiety* was equated by Lambo (1960) with the *bouffée délirante* of his francophone colleagues in West Africa. An identical condition has been reported by Burton-Bradley (1975) as "New Guinea transitory delusional state". Associated with these transient reactive psychoses is the danger of aggressive discharge and violent acts, well documented in African forensic psychiatry. It is of interest that the term *frenzied anxiety* was originally introduced in Kenya by Carothers (1947) for acute brief psychotic reactions with aggressive, often homicidal behaviour similar to the *amok* syndrome of Malaysian cultures but unlike the latter usually precipitated by fears of bewitchment.

Many possible organic etiologies have been considered as underlying causes of transient psychotic reactions in tropical areas (cf. list in Jilek & Jilek-Aall 1970), but have rarely been demonstrated in the examined cases. This prompted Lambo (1965) to emphasize the role of socio-cultural factors in a summarizing statement: "These reactions would seem to be much more related to culture than to infection". At risk are the "marginal" Africans, the detribalized, semi-Westernized new townspeople, among whom morbid fear of bewitchment is prevalent and who are "in the process of renouncing, or have unsuccessfully renounced, their age-old culture but have failed to assimilate the new" (Lambo 1962). Collomb, after having for some time considered certain aspects of personality development in the African as pathoplastic determinants of transient psychotic reactions, finally concluded that conflicting values and role confusion in the context of rapid socio-cultural transformation are the most relevant factors: "Dans les sociétés en voie de transformation, des valeurs nouvelles et des personnages nouveaux sont proposés. Les rôles sont brouillés, la place est incertaine ou perdue, c'est le désarroi et l'angoisse et l'issue vers la bouffée délirante" (Collomb 1965b). In these reactive psychotic states, anxiety becomes truly malignant if the patient's delusion of being a victim of inescapable magic retaliation, is shared by his own people. There is a high risk of letal outcome if such is anticipated by the afflicted as well as by his group, and reinforced by collective suggestion. An extreme example of socio-cultural pathogenesis is then provided by the phenomenon of "voodoo death", variously labelled *thanatomania* (Ackerknecht 1943); psychogenic death (Ellenberger 1951); *mort psychosomatique* (Collomb 1965a); or *Vagus-Tod* (Bilz 1966). "Voodoo death" was attributed by the famous physiologist Cannon (1942) to irreversible shock induced by intense emotional stress and dehydration. In her book on medical experiences in East Africa Jilek-Aall (1979, chapter 11) reports the case of a healthy young man who died because everybody expected him to die from a blood sucking spirit as he had violated a sacred taboo by trying to seduce a secluded virgin, where upon he was "cursed to death" by the girl's father.

The "hysterical" quality of transient psychoses and psychosis-like states has been referred to by several observers in Africa (cf. Jilek & Jilek-Aall 1970) and in other areas of the Third World. For the purpose of a comparative nosology, we may adduce the concept of *hysterical psychosis,* first introduced in 1860 by Morel (1860); one hundred years later revived by Hollender & Hirsch (1964) and defined as a "form of ego disruption … marked by a sudden and dramatic onset temporarily related to a profoundly upsetting event or circumstance. Its manifestation includes hallucinations, delusions, depersonalization, and grossly unusual behavior. Though disorders,

when they occur, are usually sharply circumscribed and very transient. Affectivity, if altered, is changed in the direction of volatility and not flatness.

The acute episode seldom lasts longer than 1-3 weeks, and the eruption is sealed off so that there is practically no residue". This "hysterical" quality has also been noted for the so-called *culture-bound syndromes* which are often thought of as distinct disease entities, generated by culture-specific pathogenic factors. However, Yap who introduced the term "culture bound reactive syndromes" in the 1960's, understood them as culture-bound only in the sense that their symptom patterns are determined by cultural factors in form and frequency. He compiled lists of culture bound syndromes and devised classifications in terms of phenomenological description (Yap 1969, 1974). Yap proposed that the "culture bound reactive syndromes" can be classified according to the apparently predominant clinical symptom formation in the following schema (Yap 1969: 42)

1. Paranoid syndromes
2. Emotional syndromes
2.1 Depersonalization states: *koro*
2.2 Fear-induced depressive states: *susto*
3. Syndromes of disordered consciousness
3.1 Impaired consciousness: *latah* reaction
3.2 Turbid states: malignant anxiety, *amok, negi-negi*
3.3 Dissociated consciousness: certain types of possession syndrome, *hsi-eh-p-ing; windigo* psychosis.

This classification by Yap was an attempt to apply German and Scandinavian scientific taxonomies of reactive psychogenic psychoses to exotic terms. Such a classification is less than satisfactory in practice, as the categorizing symptoms—paranoid, emotional, and disordered consciousness—are found in most of the listed *emic* (i.e. denoted by indigenous folk-terms) conditions, and are in some instances of equal importance. A brief summarizing description of the best known culture bound syndromes will illustrate that a wholesale translation of these emic disease terms into *etic* (Western scientific observer's) categories is not advisable.

Koro *(Suo-Yang,* "shrinking penis"): In traditional Taoist medical philosophy a disorder due to disturbance of the *yin-yang* equilibrium. Panic state with fears of impending death associated with somatic delusions of shrinking of the penis and retraction of the external genitalia into the abdomen, which is believed to have lethal consequence. Occurring as culturally defined condition in Southern China, Hong Kong, Southeast Asia (cf. Yap 1965).

Susto; Espanto ("fright", "terror"): Fear and fright reactions of heterogenous phenomenology are subsumed under these Spanish terms, in accordance with Amerindian mythology and syncretistic beliefs common among Indio and Mestizo populations of the Andean countries, Central America, Mexico and among related Hispano-American groups in North America (cf. Sal y Rosas 1960; Rubel 1964; Seguin 1979).

Latah ("Nervous", "upset", "ticklish"): Anxiety reaction triggered by specific startle stimuli. Characterized by echo- and coprolalia, echopraxia, automatic obedience, and/or by impulsive behaviour of counter aggressive type. Occurring as culturally defined condition in Malaysia and Indonesia (cf. Yap 1952, Pfeiffer 1971, Murphy 1976). Analogous culturally defined syndromes are ***imu*** among the Ainu of Hokkaido, ***bah-che*** in Thailand, ***yaun*** in Burma, ***mali-mali*** in the Philippines, ***miryachit*** in Eastern Siberia, ***Lapp panic*** in Lapland, and the "Jumpers" syndrome in Maine, USA (Beard 1880). Endemic reactions of *latah* type occur also in Libya and Yemen. Simons (1980) has recently shown that the various forms of *latah* are socio-cultural exploitations of a neurophysiological potential which is shared by humans and other mammals.

Amok *(amuak, camoo,* originally a Portuguese term used for South Asian warriors vowing to fight to death, in the manner of the "morituri" of ancient Rome). According to the classic definition by van Wulfften Palthe (1933), a psychogenic twilight state with sudden discharges of apparently unmotivated random violent, homicidal behaviour which is often terminated by a suicidal act. Occurring as culturally defined syndrome in Malaysia, Indonesia and the Philippines (cf. Yap 1969; Pfeiffer 1971). Amok-like reactions occur also in Papua New Guinea under various indigenous names (cf. Burton-Bradley 1968, 1975). Malignant anxiety states associated with homicidal behaviour in Africans have been termed *pseudo-amok* or amok-like reactions (cf. Jilek & Jilek-Aall 1970).

Windigo *(Witiko, Wintsigo, Windikouk).* Among the Algonkian Indians of Northeastern and North-central Canada, *Windigo* denotes a cannibalistic monster of giant size with a heart of ice. The victim is first possessed by the spirit of the *windigo* and then

turns into one himself. Unable to restrain his aggressive cannibalistic impulse, he may be executed by his band on grounds of self-defense (cf. Teicher 1960).

***Pibloktoq** (Arctic hysteria)*. Acute anxiety state of sudden onset usually triggered by an upsetting experience, with dramatic and potentially dangerous behaviour, such as screaming and trembling, throwing off clothes in sub-zero weather, wild running or rolling in the snow, jumping into the icy water; sometimes also directly aggressive acts against self or others. The afflicted person appears confused and usually claims amnesia for the attack which, if not interrupted, may last an hour or more, often ending in sleep or stupor-like exhaustion. Occurs among the polar Inuit (Eskimo) of Greenland and arctic Canada, mostly in women (cf. Brill 1913; Gussow 1960). Calcium deficiency rooted in culturally sanctioned dietary habits, has been demonstrated in this condition (Wallace 1972), thus constituting a true pathogenic factor. *Kayak-angst* is related phobic-anxiety state occurring in conditions of sensory deprivation among male Inuit hunters in Greenland (Gussow 1963).

The emergence, metamorphosis, epidemiological prominence and eventual decline, of culture bound syndromes under the effects of societal and cultural change has been demonstrated for *amok* and *latah*.*

Teoh (1972) showed how under negative societal sanctions *amok* evolved from a deliberately induced, conscious form of revenge seeking suicidal behaviour, tolerated in Muslim Malayan societies, to an unconsciously motivated psychiatric syndrome of diverse etiology. In his detailed historical study, Murphy (1973) documented the decline in incidence of *amok* in centers exposed to European colonial influence from the mid-19th century onwards, with a marked shift from consciously motivated behaviour to dissociative reaction in otherwise normal individuals, and a further shift to episodic occurrence in the course of mental illness. Murphy (1973) also documented the first appearance of *latah* during the second half of the 19th century at a time of consolidation of the European colonial system. *Latah* spread rapidly among those indigenous populations which were under direct European influence; it subsequently moved away from these centers to more distant areas where it is found today. The previously observed male form has almost disappeared, the intensity of attacks has decreased, and the residual subjects appear less intelligent than the earlier ones. Murphy (1973) concluded that the syndromes of *amok* and *latah* "are best conceived not as offshoots from Malaysian cultural tradition but as the transitional products of an interaction between that tradition and certain modernizing influences".

Under conditions of acute socio-cultural and politico-economic stress which affects not only an individual but his entire group, culture bound syndromes which usually occur in isolated cases, may assume epidemic proportions, especially in times of international or inter-racial tension. Czaplicka (1914) reported an episode during the Russo-Japanese war in which *miryachit,* the Siberian equivalent of *latah,* was collectively manifested by a military unit "Once, during a parade of the 3rd Battalion of the Trans-Baikal Cossacks, a regiment composed entirely of natives, the soldiers began to repeat the words of command. The colonel grew angry and swore volubly at the men; but the more he swore, the livelier was the chorus of soldiers repeating his curses after him".

In 1976 we were able to observe the unfolding of a *koro* epidemic in Thailand among rural Thai people in whom this supposedly Southern Chinese syndrome had been practically unknown. There were rumors and media reports of sensational food poisonings allegedly perpetrated by the Vietnamese in a sinister plot to sabotage health and sex life of the Thai nation. The epidemic appears to have originated among students of a Technical College in the northeastern

* Author's note, 2010. My further study of the so-called Culture Bound Syndromes suggests the following classification: (1) Syndromes related to Cultural Emphasis on Fertility and Procreation ("Genital Shrinking" *koro*-type Syndromes; "Semen Loss" Syndromes); (2) Syndromes related to Cultural Emphasis on Learnt Dissociation (*Latah*-type reactions; *Amok*-type reactions); (3) Syndromes related to Cultural Emphasis on presenting a Pleasing Physical Appearance (Anthropophobia among Japanese and Koreans); (4) Syndromes related to Acculturative Stress in situations of rapid socio-cultural change ("Brain fag" among African students abroad; *Boufée délirante*-type reactions among Africans and Afro-Caribbeans; Anomic Depression among indigenous minorities); (5) Culturally stereotyped reactions to Extreme Environmental Conditions (so-called "arctic hysteria" among arctic and sub-arctic populations, *Pibloktoq* and *Kayak-angst* among Inuit/Eskimo); (6) Syndromes induced by modern Western trends (e.g., *Anorexia Nervosa);* (7) Local Folk Idioms/Terms for universally known stress reactions (e.g. *Susto, Espanto,* among Latin Americans, *Hwa-byung* among Korean women). Reference: Jilek W.G. & Jilek-Aall L. 2001. Culture-Speficic Mental Disorders, Chapter 14 In Henn F., Sartorius N., Helmchen H. & Lauter H. (eds) *Contemporary Psychiatry*, Springer: New York 2001: Vol. 2, chapter 14, 218-245 / German edition: Jilek W.G. & Jilek-Aall L. 2000. Kulturspezifische psychische Störungen. In *Psychiatrie der Gegenwart*, Bd. 3, Kap. 14. Springer: Berlin-Heidelberg: 379-423.

border region who proceeded to pogrom-style retaliations against the Vietnamese ethnic minority. Within a few days about two hundred persons reported for treatment at the local hospitals of the border areas in panic states with mysterious symptoms affecting sexual and vital functions. Most of the patients were Thai peasants without knowledge of the concepts of classical Chinese medicine. Two thirds were men, among them one Buddhist monk. The complaints were stereotyped: shrinking of the penis and sexual impotence in men, shrinkage or itching of the external genitals and frigidity in women; associated symptoms were nausea, dizziness, abdominal pains, numbness, headaches. All sufferers were beset by fear of imminent death, some fainted on arrival in the hospital. After brief symptomatic treatment, or without any treatment, all patients recovered.

Nevertheless, there was widespread belief that Vietnamese agents had contaminated food stuffs, beverages and tobacco. The health authorities ordered an investigation and it was later announced that careful analysis of the accused items had detected no foreign substance that could possibly cause the reported symptoms. However, security officials were quoted in newspapers as stating that the harmful matter was a "mixture of some vegetable ingredients which could not be detected by medical devices" (*Siam Rath*, Nov. 18, 1976) and police were reported to "watch out for some Vietnamese residents who might try to put more of the allegedly poisonous powder in noodles or cigarettes" (*Dao Siam*, Nov. 15, 1976). It may be said that no true understanding of the pathogenesis of this mass hysteria with *koro* symptoms is possible on the basis of a culture-specific model referring to the pathoplastic influence of Taoist doctrines *(yin-yang* imbalance); or on the basis of a psychoanalytic model (oedipal conflicts, etc.), which have both been promulgated in explanations of *koro*. Rather, such understanding requires due consideration of the socio-cultural and politico-economical conditions of Southeast Asia, and their impinging on the individual's psychological and experiential make-up. The phenomenon of this *koro* epidemic can therefore stand as a paradigm of collective socio-cultural pathogenesis.

Transient psychotic and psychosis-like states of culture bound syndrome type are by no means the prerogative of non-European peoples. Throughout European history psychotic reactions in the context of magic beliefs were frequently recorded (cf. SUMMERS 1926, 1927). Paroxysmal behaviour closely resembling *amok* in Malaysians and malignant or frenzied anxiety in Africans, was exhibited in the berserker attacks *(berserksgangr,* Norse) of early mediaeval Scandinavia as documented by the research of WEISER-AALL (1927). The lycanthropic *werewolf* delusion of transforming into a wild beast craving for human flesh and blood was common in mediaeval Europe. In many aspects analogous to the Algonkian Indian *witiko* psychosis, this werewolf psychosis led to very similar social consequences. Under conditions of radical culture change in the transition from pagan Nordic to Judaeo-Roman-Christian civilization, *berserkers* and *werewolves* increased in number and destructiveness, some times to epidemic proportions (LAIBLIN 1965). Until the mid-19th century, a transient hallucinatory excitement state with hysteriform paroxysms and delusions of daemoniac possession, called *Daemono-Melancholie,* was a frequently encountered clinical condition in Central Europe, according to GRIESINGER (1867) the pioneer of German scientific psychiatry. Acute psychotic reactions of brief duration and favorable outcome, precipitated by intense fear of witchcraft or sorcery, are not at all rare in contemporary Europe. JACQUES and MOREL (1965) reported on delusions of bewitchment (délire de sorcellérie) in Northwestern France. In Switzerland, RISSO & BÖKER (1964) investigated South Italian "guest workers" who had been hospitalized with symptoms of frenzied excitement, fear or imminent death, floating hallucinations and paranoid behaviour, all in the context of delusions of bewitchment and sorcery *(fattura)*. Experiencing a culture shock when exposed to a foreign milieu with alien norms of conduct, especially in the area of interpersonal relations between the sexes, these migrant workers developed paranoid psychotic states. There was a tendency to (mis-)diagnose these cases as schizophrenia, although they responded well to suggestive assurance and brief sedation with speedy recovery and without any chronicity or residual defects. The authors felt that in the framework of Swiss diagnostic nomenclature, these cases would fit well into the category "schizophrenia-like emotional psychosis" (cf. LABHARDT 1963); defined as transient and brief psychotic reaction of acute schizophrenic type; precipitated by severe emotional stress, often in the context of a "magic-archaic" world view, and responding well to milieu and psychotherapeutic measures. We at once recognize the close relationship of this Swiss diagnostic

entity with (1) the *hysterical psychosis* as defined by HOLLENDER & HIRSCH (1964); and with (2) the *bouffée délirante* of French authors. French psychiatry, by maintaining the latter diagnosis independent of the concepts of schizophrenia and hysteria, is avoiding much of the controversy surrounding the classification of acute transient psychotic reactions in general, and of culture bound syndromes in particular.

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

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Wolfgang George Jilek (*25.11.1930), Dr. med. (Innsbruck), M.A.(Anthropology, Vancouver), Clinical Professor of Psychiatry Emeritus (Vancouver). Special areas of research: Comparative Cultural Psychiatry, Ethnopsychology, "Ethnomedizin" (folkpsychiatry); epilepsy in developing countries; symbolism in healing rituals. Research in East Africa (1963), Haiti (1964), South America (1971,1979), Thailand (1976, 1988/89), New Guinea (1976, 1985), since 1966 northwestern American Indians, and many others. He is a founding member of the Transcultural Psychiatry Section of the World Psychiatric Association and was its Secretary 1983-1993 and Chairperson 1993-1999, organizing international cross-cultural symposia in several countries. He has published three books and 134 scientific articles and book chapters. Advisor of the World Association of Cultural Psychiatry, Hon. Member of AGEM (Working Group Ethnomedizin/Medical Anthropology, Germany); Hon. Member of GLADET (Ethnopsychiatry, Latin America).

"Casa Miramar", 571 English Bluff Rd., South Delta, B.C., Canada V4M 2M9
e-mail: jilek@telus.net