

Psychiatric Labeling in Cross-Cultural Perspective

Similar kinds of disturbed behavior appear
to be labeled abnormal in diverse cultures.

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In recent years labeling (or societal reaction) theory has aroused strong interest among people concerned with mental illness. From the perspective of labeling theory, the salient features of the behavior patterns called mental illness in countries where Western psychiatry is practiced appear to be as follows: (i) these behaviors represent deviations from what is believed to be normal in particular sociocultural groups, (ii) the norms against which the deviations are identified are different in different groups, (iii) like other forms of deviation they elicit societal reactions which convey disapproval and stigmatization, (iv) a label of mental illness applied to a person whose behavior is deviant tends to become fixed, (v) the person labeled as mentally ill is thereby encouraged to learn and accept a role identity which perpetuates the stigmatizing behavior pattern, (vi) individuals who are powerless in a social group are more vulnerable to this process than others are, and (vii) because social agencies in modern industrial society contribute to the labeling process they have the effect of creating problems for those they treat rather than easing problems.

This school of thought emerged mainly within sociology, as an extension of studies of social deviance in which crime and delinquency were originally the major focus (1). It is also associated with psychiatry through, for example, Thomas Szasz and R. D. Laing (2). These ideas have come to be called a "sociological model" of mental illness, for they center on learning and the social construction of norms. They began to be formulated about 25 years ago (3), commanded growing attention in the late 1960's, and have been influential in recent major changes in public programs for psychiatric care, especially the deinstitutionalization which is occurring in a number of states (4, 5).

Several aspects of the theory receive

support from a study reported in *Science* by David Rosenhan (6), based on the experiences of eight sane subjects who gained admission to psychiatric hospitals, were diagnosed as schizophrenic, and remained as patients an average of 19 days until discharged as "in remission." Rosenhan argues that "we cannot distinguish insanity from sanity" (6, p. 257). He associates his work with "anthropological considerations" and cites Ruth Benedict (7) as an early contributor to a theme he pursues, which is that "what is viewed as normal in one culture may be seen as quite aberrant in another" (6, p. 250). He indicates that the perception of behavior as being schizophrenic is relative to context, for "psychiatric diagnosis betrays little about the patient but much about the environment in which an observer finds him." He argues that, despite the effort to humanize treatment of disturbed people by calling them patients and labeling them mentally ill, the attitudes of professionals and the public at large are characterized by "fear, hostility, aloofness, suspicion, and dread." Once the label of schizophrenia has been applied, the "diagnosis acts on all of them"—patient, family, and relatives—"as a self-fulfilling prophecy. Eventually, the patient himself accepts the diagnosis, with all of its surplus meanings and expectations, and behaves accordingly" (6, p. 254).

The research to be described here presents an alternative perspective derived from cross-cultural comparisons, mainly of two widely separated and distinctly contrasting non-Western groups, Eskimos of northwest Alaska and Yorubas of rural, tropical Nigeria. It is concerned with the meanings attached to behaviors which would be labeled mental illness in our society. I interpret these data as raising important questions about certain assumptions in the labeling thesis and therefore as casting doubt on its validity as a major ex-

planation of mental illness, especially with respect to schizophrenia. These cross-cultural investigations suggest that relativism has been exaggerated by labeling theorists and that in widely different cultural and environmental situations sanity appears to be distinguishable from insanity by cues that are very similar to those used in the Western world.

The Labeling Orientation

As Edwin Schur (8) points out, if labeling theory is conceived broadly it is the application of George Herbert Mead's theories about self-other interactions to a definition of social deviance extended to include human problems ranging from crime to blindness. Labeling theory emphasizes the social meanings imputed to deviant behavior and focuses on the unfolding processes of interaction whereby self-definition is influenced by others. Further, "it is a central tenet of the labeling perspective that neither acts nor individuals are 'deviant' in the sense of immutable, 'objective' reality without reference to processes of social definition." Schur states that "this relativism may be viewed as a major strength" of labeling theory (8, p. 14).

Edwin Lemert's concept of secondary deviance (9) is of critical importance in linking self-other considerations to deviations. Secondary deviation occurs when a person learns the role and accepts the identity of a deviant as the basis of his lifestyle. It is a response to a response; negative feedback from significant others reinforces and stabilizes the behavior that initially produced it. Applied to criminality, this idea has created general awareness of a process whereby a young person on being labeled a juvenile delinquent may enter a network of contingencies that lead ultimately to his learning criminal activities and "hardening" as a criminal rather than to the correction of behavior.

In *The Making of Blind Men*, Robert Scott points to a similar process regarding a very different type of deviance (10). If a person is labeled blind by certain administrative criteria he is likely to become enmeshed in care-giving agencies that encourage him to accept a definition of himself as helpless and to learn to play the role of the blind man. These experiences may even inhibit the use of residual vision. Scott shows that institutions for the blind vary in the degree to which they encourage acceptance or rejection of the deviant role and that these differences are related to

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differences in the life-style of blind men. Insofar as the labeling concept has been employed in this way I believe it is sound and has disclosed new and valuable information.

The application of labeling ideas to mental illness has tended to take a different course (11) and has aroused considerable controversy, as indicated, for example, in the continuing exchange between Thomas Scheff and Walter Gove *et al.* (12-15). One question in this controversy is whether mental illness should be considered a "pure case" of secondary deviation or a more complex case. Lemert's formulation of the concept of secondary deviation was influenced by his investigation of stuttering, and he suggests that stuttering represents the pure case: "Stuttering thus far has defied efforts at causative explanation. . . . It appears to be exclusively a process-product in which, to pursue the metaphor, normal speech variations, or at most, minor abnormalities of speech (primary stuttering) can be fed into an interactional or evaluational process and come out as secondary stuttering" (9, p. 56).

The important point here is that primary deviance is considered to be normal variation or only "minor abnormalities," and the influence of societal reactions is considered genuinely causative. Societal reactions "work on" and "mold" normal variations of speech to "create" stuttering. For mental illness the labeling theorists have tended to use the "pure case" model rather than the more complex model represented by blindness, where lack or loss of sight is primary deviance and the role of blind man is secondary deviance.

Scheff has provided the most systematic theoretical statement regarding labeling and mental illness, and in his formulation the primary deviations that are fed into interactional processing to come out as mental illness are described as "amorphous," "unstructured," and "residual" violations of a society's norms (11, pp. 33, 82). Rosenhan suggests that the behaviors labeled schizophrenic might be "'sane' outside the psychiatric hospital but seem insane in it . . . [because patients] are responding to a bizarre setting" (6, p. 257). Lemert says that social exclusion can "create a paranoid disposition in the absence of any special character structure" (9, p. 198). Further, many have posited that behavior we call mental illness might be considered normal in a different culture or in a minority social class. Thus, the primary deviations of mental illness are held to be for the most part insignificant, and societal reactions become the main etiologic factor.

This view is reminiscent of ideas about human plasticity, cultural determinism, and cultural relativism which were promi-

nent in what used to be called the culture-personality studies of anthropology. In fact the influence of culture-personality on labeling theory is explicitly stated by Lemert, who was trained jointly in sociology and anthropology and who has drawn on non-Western studies throughout his career. The influence is equally acknowledged by Rosenhan (6). It seems to me that numbers of proponents of labeling theory assume that the expanding body of data from non-Western areas has supported the relativist propositions put forth by Benedict and others in the 1930's and '40's (16). Indeed, it was my own assumption when I began anthropological work with Eskimos. I thought I would find their conception of normality and abnormality to be very different, if not opposite, from that held in Western culture. This did not prove to be the case, and my experience is not unique. Anthropologists who have been conducting field research in recent years using more systematic methods but continuing to work on the relations between individual behavior and cultural context tend to hold a greatly modified view of the extent of individual plasticity and the molding force of culture (17, 18).

It would be misleading on my part to imply that all theory building and investigation regarding the relation of labeling and mental illness have followed the pure-case model. In their studies on mental retardation Robert Edgerton and Jane Mercer use moderate labeling ideas and show that social reactions are related to differences in the ways subnormal individuals are able to function both in and outside of institutions (19). A growing number of studies of alcoholism, many of them influenced by labeling views, have demonstrated that social attitudes and the variable meanings attached to drinking are correlated with marked differences in alcoholism rates in various cultural groups (20). There are, in addition, numbers of studies of the social pathways leading to hospitalization, the impact of hospitalization, attitudes toward discharged mental patients, and so on which reveal important outcomes for the mentally ill without imputing to societal reactions the degree of significance given them in the more deterministic formulations.

Most labeling studies of mental illness have been carried out in the United States and the United Kingdom. Variations in the definition and tolerance of mental illness have mainly been studied in groups at different social class levels in industrialized society (21). Since cultural relativism is one of the main elements of the orientation, it seems useful to put some of the basic labeling questions to non-Western data. As background for this, I quote from four

contributors to labeling theory: Scheff, Erving Goffman, Theodore Sarbin, and David Mechanic. These references do not encompass the breadth and elaboration of each contributor's own approach to the problem of mental illness, but they do reflect the view of cultural relativity which runs throughout the labeling orientation.

Scheff says that "the culture of the group provides a vocabulary of terms for categorizing many norm violations" (11, pp. 33, 82). These designate deviations such as crime and drunkenness. There is a residual category of diverse kinds of deviations which constitute an affront to the unconscious definition of decency and reality uniquely characteristic of each culture. Scheff posits that the "culture provides no explicit label" for these deviations but they nevertheless take form in the minds of societal agents as "stereotypes of insanity." When people around a deviant respond to him in terms of these stereotypes, "his amorphous and unstructured rule-breaking tends to crystallize in conformity to these expectations." Scheff further suggests that these cultural stereotypes tend to produce uniformity of symptoms within a cultural group and "enormous differences in the manifest symptoms of stable mental disorder between societies."

It has been pointed out that there appears to be a contradiction in one aspect of Scheff's theory (12, p. 876; 22). It is difficult to accept that a socially shared image of behavior that can influence action and has the concreteness of a stereotype should lack a name. It is possible Scheff meant that in the evolution of language a label for insanity was the last to emerge because it refers to a residue of norm violations. The dating of words is beyond the scope of the data to be presented here, but it will be possible to see whether an explicit label currently exists in the two cultures studied, a hunting-gathering culture (Eskimo) and an agricultural society (Yoruba), neither of which developed a written language. If a word for insanity occurs we can then investigate the kinds of behaviors therein denoted.

Regarding our own society, Goffman stresses that the "perception of losing one's mind is based on culturally derived and socially engrained stereotypes as to the significance of symptoms such as hearing voices, losing temporal and spatial orientation, and sensing that one is being followed" (23). He further indicates that there is cultural variation in this kind of imagery and differential encouragement for such a view of oneself. This makes it appropriate to ask whether hallucinations, delusions, and disorientations are present or absent from the conception of losing one's mind in Yoruba and Eskimo cul-

tures, assuming they have a stereotype of insanity at all.

Labeling theorists express considerable dissatisfaction with the concept of mental illness, pointing out that it is a vague and euphemistic metaphor and ties together phenomena that are neither "mental" nor "illness." They argue that mental illness is a myth developed in Western societies, that the term represents an abortive effort to improve the treatment of people previously called lunatics, that in the name of this myth we continue to incarcerate, punish, and degrade people for deviating from norms. Sarbin suggests that defining behavioral aberrations as illness occurred in medieval Europe as a way to relabel people who might otherwise have been burned at the stake as witches (24). He further suggests that it was during this phase of Western history that the concept of mind came into being. It was used as a way to explain perplexing behavior that could not be related to occurrences external to the person. It is "as if there are states of mind" that cause these patterns of conduct. The "as if" was transmuted into the myth that the mind exists as a real entity and can therefore be sick or healthy.

In the data to be given, it will be possible to ask whether the idea of an inner state that influences conduct is found in these non-Western groups and, since both groups believe in witchcraft, whether a stereotype of insanity is associated with the conduct of witches. Everywhere that witchcraft has been systematically studied the role of the witch involves deviances that are heavily censured. The witch carries out practices that are believed to harm people through supernatural means. If the insane person and the witch are equated in the beliefs of non-Western groups, it would appear to follow that in those groups mental illness is thought of as social deviance; and this would be a telling point for labeling theory.

Mechanic makes the point that "although seemingly obvious, it is important to state that what may be viewed as deviant in one social group may be tolerated in another, and rewarded in still other groups" (25). He emphasizes that the social response may influence the frequency with which the deviant behavior occurs. It has been hypothesized by a number of researchers that holy men, shamans, or witch doctors are psychotics who have been rewarded for their psychotic behavior by being made incumbents of highly regarded and useful roles (26). This is the obverse of the possibility that the insane are thought of as witches. The role of the healer carries great power and approval. The idea of social rewards for mental illness underscores the lengths to which relativity can be car-

ried, for it suggests that the social definition of one kind of behavior can turn it into such opposing roles as the defamed witch or the renowned shaman. Mechanic's points make it appropriate, therefore, to ask whether the shamans in Eskimo culture and the healers in Yoruba culture are thought by the people to be mentally ill and whether the rates of such mental illness in these groups are similar to or different from those in the West.

Scheff, Goffman, Sarbin, and Mechanic share the view that in our society the appellation "mentally ill" is a "stigmatizing" and "brutalizing" assessment. It robs the individual of identity through profound "mortification" and suggests that he is a "non-person." It forces him into an ascribed role, exit from which is extremely difficult. Thus another question is posed: If Eskimos and Yorubas have a stereotype of insanity, are they less harsh than we with those defined as insane?

To illustrate the model I have in mind for exploring these questions I will first describe a non-Western event which suggests that certain aspects of labeling theory are valid. It does not concern mental illness but it demonstrates the use of labels as arbitrary social definitions in the labeling theory sense. The case is reported by W. H. R. Rivers in connection with his analysis of the concept of death among the Melanesians (27):

Some persons who are seriously ill and likely to die or who are so old that from the Melanesian point of view they are ready to die are labeled by the word *mate*, which means "dead person." They become thereby subjects of a ceremonial live burial. It can be argued that the Melanesians have a concept of death which is a social fiction. It embodies what they arbitrarily agree to define as death and is a distortion of reality as seen by most cultural groups. The label *mate* involves a degradation ceremony in which an elderly person is deprived of his rights and is literally "mortified." He is perceived "as if dead" and then buried. The linguistic relativist might even say that this use of the word *mate* shows that the Melanesians do not perceive death by means of the indicators of vital functioning applied in Western society (28).

Rivers's own conclusion is that the Melanesians view death the way we do and are cognizant of the difference between biological and social *mate*. Biological *mate* is by far the commoner phenomenon. In their practice of live burials the Melanesians in fact take close note of two typical precursors of death—old age and illness.

It seems clear, however, that socially sanctioned acts based on symbolic meanings, such as those involved in social *mate*, are powerful in influencing the course of

human affairs. They can be treacherously abused and lead to what we think of as cruel outcomes. Rivers says that the practice is not conceived to be cruel or degrading by the Melanesians because in their meaning the burial relieves the person of a worn-out earth-life so that he can enter the higher status of the spiritual afterlife. By our standards the Melanesian interpretation would nevertheless be considered a collective rationalization of "geronticide." Whatever the intent, the socially defined death of elderly Melanesians is a myth and serves as a model of what I understand the labeling theorists to mean by the "myth of mental illness." Thus a final question: Do the Eskimos and Yorubas subscribe to such fictions about mental illness through which they perpetrate inhumanity and degradation?

Method of Study

The data to be presented derive mainly from a year of field work, in 1954–55, in a village of Yupik-speaking Eskimos on an island in the Bering Sea, and an investigation of similar length, in 1961 and 1963, among Egba Yorubas. I also draw on shorter periods of field work in Gambia, Sudan, and South Vietnam.

Some of the Eskimo data came from a key informant, who systematically described the life experiences of the 499 Eskimos who constituted a total village census over the 15 years previous to and including the year of investigation. In addition, a dictionary of Eskimo words for illness and deviance was developed. Extended life histories of a small number of Eskimos were gathered. Also daily observations and comments from Eskimos about Eskimos (both in their own village and in other areas known to them) were recorded for the purpose of understanding their conceptions of behavior (29).

The approach among the Yorubas was different in that I worked with a group of three native healers and a member of an indigenous cult. Interviews were directed toward understanding Yoruba concepts of behavior in the abstract and centered on actual people only to the extent that acquaintances and patients were brought into the discussion as illustration (30).

The Eskimo data served as the base for an epidemiological study of the village in 1955, and the Yoruba data constituted one of the first phases of a larger epidemiological study carried out with a group of Nigerian and U.S. colleagues in which we studied 416 adults, of whom 245 constituted a representative sample from 14 villages (31).

In *The Social Meanings of Suicide*, a

study affiliated with the labeling tradition, Jack Douglas has shown the weakness of official statistics as a basis for judging the social significance of behavioral phenomena in groups (32). The Eskimo and Yoruba studies reflect a similar orientation about the inadequacies of mental hospital statistics for the purposes at hand. As has been done in many labeling studies, I relied on participant observation and interviewing about microcultural events. The focus was on indigenous meanings. These meanings were then used as a basis for counting similar behavior patterns, so that they were defined from within a cultural group rather than by imposed criteria.

In these studies I have considered language to be the main repository of labels. Insofar as there is a counterpart to the official recognition of mental illness involved in hospital commitment in a Western society, it resides in what Eskimos and Yorubas say are the kinds of people treated by shamans and native healers.

Labeled Behavior Patterns

The first specific question is: Do Eskimos and Yorubas have labels for psychological and behavioral differences that bear any resemblance to what we mean by mental illness? These groups clearly recognize differences among themselves and describe these in terms of what people do and what they say they feel and believe. Some of the differences lead people to seek the aid of healers and some do not, some differences arouse sympathy and protection while others arouse disapproval, some are called sickness and others health, some are considered misconduct and others good conduct. Some are described by a single word or nominative phrase. Some that seem to have common features are described in varying circumlocutions and sentences. If a word exists for a complex pattern of behavior it seems acceptable to assume that the concept of that pattern has been crystallized out of a welter of specific attributes and that the word qualifies as an explicit label.

Of major importance is whether or not the Yorubas and Eskimos conceptualize a distinction between body and mind and attribute differences in functioning to one or the other. The first indication of such a distinction arose early in the Eskimo census review when a woman was described in these terms: "Her sickness is getting wild and out of mind . . . but she might have had sickness in her body too." The Eskimo word for her was *nuthkavihak*. It became clear from other descriptions that the word refers to a complex pattern of behavioral processes of which the hallmark is con-

ceived to be that something inside the person—the soul, the spirit, the mind—is out of order. Descriptions of how *nuthkavihak* is manifested include such phenomena as talking to oneself, screaming at someone who does not exist, believing that a child or husband was murdered by witchcraft when nobody else believes it, believing oneself to be an animal, refusing to eat for fear eating will kill one, refusing to talk, running away, getting lost, hiding in strange places, making strange grimaces, drinking urine, becoming strong and violent, killing dogs, and threatening people. Eskimos translate *nuthkavihak* as "being crazy."

There is a Yoruba word, *were*, which is also translated as insanity. The phenomena include hearing voices and trying to get other people to see their source though none can be seen, laughing when there is nothing to laugh at, talking all the time or not talking at all, asking oneself questions and answering them, picking up sticks and leaves for no purpose except to put them in a pile, throwing away food because it is thought to contain *juju*, tearing off one's clothes, setting fires, defecating in public and then mushing around in the feces, taking up a weapon and suddenly hitting someone with it, breaking things in a state of being stronger than normal, believing that an odor is continuously being emitted from one's body.

For both *nuthkavihak* and *were* indigenous healing practices are used. In fact, among the Yorubas some native healers specialize in the treatment of *were* (33, 34).

The profile of *were* behaviors is based not only on what the healers described in the abstract but also on data concerning two members of the sample identified as *were* by the village headman and a group of 28 *were* patients in the custody of native healers and in a Nigerian mental hospital. The profile of *nuthkavihak* is built from information about four individuals within the 15-year population of 499 persons and six Eskimos from earlier times and from a related Eskimo settlement in Siberia.

Of paramount significance is the fact that *were* and *nuthkavihak* were never used for a single phenomenon such as hearing voices, but rather were applied to a pattern in which three or four of the phenomena described above existed together. It is therefore possible to examine the situations in which a person exhibited one or another of the listed behaviors but was not labeled insane.

The ability to see things other people do not see and to look into the future and prophesy is a clearly recognized and highly valued trait. It is called "thinness" by Eskimos. This ability is used by numerous minor Eskimo diviners and is the out-

standing characteristic of the shaman. The people called "thin" outnumber those called insane by at least eight to one. Moreover, there were no instances when a "thin" person was called *nuthkavihak*.

When a shaman undertakes a curing rite he becomes possessed by the spirit of an animal; he "deludes" himself, so to speak, into believing that he is an animal. Consider this description (35):

The seance is opened by singing and drumming. After a time the shamaness falls down very hard on the floor. In a while, the tapping of her fingers and toes is heard on the walrus skin floor. Slowly she gets up, and already she is thought to "look awful, like a dog, very scary." She crawls back and forth across the floor making growling sounds. In this state she begins to carry out the various rites which Eskimos believe will cure sickness, such as sucking the illness out of the body and blowing it into the air. Following this the shamaness falls to the floor again and the seance is over.

Compare this to the case, reported by Morton Teicher, of a Baffin Island Eskimo who believed that a fox had entered her body (36). This was not associated with shamanizing but was a continuous belief. She barked herself hoarse, tried to claw her husband, thought her feet were turning into fox paws, believed that the fox was moving up in her body so that she could feel its hair in her mouth, lost control of her bowels at times, and finally became so excited that she was tied up and put into a coffin-like box with an opening at the head through which she could be fed. This woman was thought to be crazy but the shamaness not. One Eskimo summarized the distinction this way: "When the shaman is healing he is out of his mind, but *he is not crazy*." Figure 1 is a picture selected by an Eskimo to illustrate the shaman's appearance during a seance (37).

This suggests that seeing, hearing, and believing things that are not seen, heard, and believed by all members of the group are sometimes linked to insanity and sometimes not. The distinction appears to be the degree to which they are controlled and utilized for a specific social function. The inability to control these processes is what is meant by a mind out of order; when a mind is out of order it will not only fail to control sensory perception but will also fail to control behavior. Another Eskimo who was asked to define *nuthkavihak* said that it means "the mind does not control the person, *he is crazy*." I take this to mean that volition is implicated, that hearing voices, for example, can be voluntary or involuntary, and that it is mainly the involuntary forms that are associated with *were* and *nuthkavihak*.

In cultures such as Eskimo and Yoruba, where clairvoyant kinds of mental phenomena are encouraged and preternatural

experiences are valued, something similar to what we might call hallucinations and delusions can probably be learned or simulated. A favorable audience reaction is likely to stabilize the performance of the people who fill the roles of fortune-teller and faith healer. For example, the shamaness described above was unable to keep her patient alive but her performance was considered to have been well executed; she was said to have done "all her *part*, acting like a dog." The Eskimos believe that a person can learn to be a shaman. Their view of *nuthkavihak* is something that befalls the person, a pattern of behavioral processes that can appear and disappear, lasting a long time with some people and a short time with others.

A number of researchers in the field of cross-cultural psychiatry take the position that the underlying processes of insanity are the same everywhere but that their specific content varies between cultural groups (38). A psychotic person, it is thought, could not make use of the imagery of Christ if he had not been exposed to the Christian tradition and he could not elaborate ideas about the *wittiko* cannibalistic monster if not exposed to Cree and Ojibwa Indian traditions (39). It would seem that if a culture-specific stereotype of the con-

tent of psychosis exists in a group it might have the kind of influence suggested in labeling theory. If the content stereotype were applied to the unstructured delusions of a psychotic his thought productions might be shaped and stabilized around the theme of that stereotype.

There have been several attempts to study phenomena such as *wittiko* and *pibloktoq*, the former being thought of as the culturally defined content of a psychotic process in which the person believes himself to be a cannibalistic monster and the latter as a culture-specific form of hysteria found in the arctic (40, p. 218; 41). The evidence of their existence comes from early ethnographies. It has been difficult in the contemporary period to locate people who have these illnesses (42). If the availability of a content stereotype has the effect one would expect from labeling theory, the stereotype should have sustained the pattern, but in fact these content patterns seem to have disappeared.

Prominent in the descriptions of the images and behavior of people labeled *were* and *nuthkavihak* were cultural beliefs and practices as well as features of the natural environment. Eskimo ideation concerned arctic animals and Eskimo people, objects, and spirits. The Yoruba ideation was based

on tropical animals and Yoruba figures. The cultural variation was, in other words, general. There was no evidence that if a person were to become *were* or *nuthkavihak* he would reveal one specific delusion based on cultural mythology. In this regard I reach the same conclusion as Roger Brown did when he set out to see how far labeling ideas would aid his understanding of hospitalized schizophrenics: "Delusions are as idiosyncratic as individual schizophrenics or normals. . . . There seems to be nothing like a standard set of heresies, but only endless variety" (15, p. 397).

The answer to the first specific question, whether Eskimos and Yorubas have labels for psychological and behavioral differences resembling what we call mental illness, is to my mind a definite yes. The expanding ethnographic literature on this topic indicates that most other non-Western groups also have such labels [in addition to the papers already cited see (43)]. From this broad perspective it appears that (i) phenomenal processes of disturbed thought and behavior similar to schizophrenia are found in most cultures; (ii) they are sufficiently distinctive and noticeable that almost everywhere a name has been created for them; (iii) over and above similarity in processes, there is variability

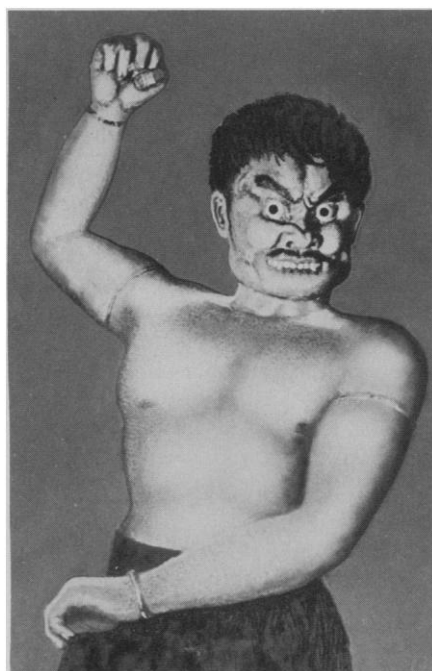


Fig. 1 (left). The shaman during seance: "he is out of mind but not crazy." Fig. 2 (right). A man living on an abandoned anthill: "he is out of mind and crazy."

in content which in a general way is colored by culture; and (iv) the role of social fictions in perceiving and defining the phenomena seems to have been very slight.

Unlabeled Behavior Patterns

The questions of this section are: Do phenomena labeled mental illness by us go unlabeled elsewhere, and if so what are the consequences? Are there natural experiments of culture which allow us to gain some understanding of the effects of not labeling? From the linguistic relativist's viewpoint, if phenomena are not named they are screened out of the perception of the people who speak that language; thus not only would mental illness go unrecognized if unlabeled but also the negative effects of labeling could not pertain.

Although one cannot speak of mental illness without reference to insanity and psychoses, most people in our culture mean more by the term and include some or all of the phenomena described in a textbook of psychiatry. Elsewhere I have presented data about Eskimo and Yoruba terms, lack of terms, and levels of generalization for mental retardation, convulsions, and senility (30, 44). According to the healers with whom I worked, the Yorubas have no word for senility but they recognize that some old people become incapable of taking care of themselves, talk to themselves, are agitated, wander away and get lost. In such cases they are watched, fed, and protected in much the same way as might be done in a nursing home. The lack of an explicit label seems to make little difference in how they are treated.

In contemporary Western society psychoneurotic patterns are thought of as one of the main types of mental illness, yet neurosis has a minor role in the labeling theory literature (45). Since labeling theory is addressed to the concept of mental illness per se, one feels it ought to apply to the neurotic as well as the psychotic.

In working with the Eskimos and Yorubas I was unable to find a word that could be translated as a general reference to neurosis or words that directly parallel our meaning of anxiety and depression. On the other hand, their words for emotional responses that we might classify as manifestations of anxiety or depression constitute a very large vocabulary. The Yoruba lexicon includes, for example, words for unrest of mind which prevents sleep, being terrified at night, extreme bashfulness which is like a sense of shame, fear of being among people, tenseness, and overeagerness. The Eskimo terms are translated as worrying too much until it makes the person sick,

too easy to get afraid, crying with sadness, head down and rocking back and forth, shaking and trembling all over, afraid to stay indoors, and so on. The point is that neither group had a single word or explicit label that lumped these phenomena together as constituting a general class of illness by virtue of their underlying similarities or as a pattern in which several components are usually found in association (46). In the terms of this article, these symptoms are unlabeled but they do exist. People recognize them and try to do something about them. Some of them are conceived as severely disabling and cause people to give up aspects of their work (such as being captain of a hunting boat); others appear to be less serious. Some of them are transient; others are life-long characteristics.

Of special significance to the problem at hand is the fact that most of these emotional phenomena are definitely thought of as illnesses for which the shaman and witch doctor have effective cures. The number of people who exhibit these phenomena is considerably in excess of those labeled *were* and *nuthkavihak*. Among the Yorubas the ratio is approximately 12 to 1 and among the Eskimos 14 to 1. In the clientele of a typical shaman or healer a large proportion would be people who came with symptoms such as "unrest of mind that prevents sleep" or "shaking and trembling all the time."

The answer to the question whether phenomena we label mental illness go unlabeled elsewhere is thus also yes. These Eskimos and Yorubas point out a large number of psychological and behavioral phenomena which we would call neuroses but which they do not put together under such a rubric. The consequence is not, however, a reduction in the number of persons who display the phenomena or great difference in how they are treated. The fact that these peoples cannot categorically define someone as "a neurotic" or that the Yorubas do not talk about "a senile" appears mainly to be a classification difference, and I am led to conclude that the phenomena exist independently of labels.

Evaluation of Behavior Patterns

Do non-Western groups evaluate the labeled behaviors of mental illness negatively or positively? Are they more tolerant of deviance than we are? I shall consider first the related institutional values of the culture, its roles and ceremonies, and then the noninstitutionalized actions and attitudes toward the mentally ill.

As pointed out earlier, it has been proposed that the shaman role is a social niche in which psychopathology is socially useful

and that therefore mental disorder is positively valued. Since the Eskimos do not believe the shaman is *nuthkavihak*, it cannot be insanity that invests the role with prestige in their eyes. It could be, however, that some other form of mental illness, possibly a neurotic disorder like hysteria, is considered essential to what a shaman does and therefore is accorded the same respect that the role as a whole commands.

Among the 499 Eskimos 18 had shamanized at some time in their lives. None was thought to be *nuthkavihak*. No other personality characteristic or emotional response was given as typical of all of them, and in these regards the shamans seemed to be a random sample of the whole. The only feature I was able to determine as common to the group was that they shamanized, and they did that with variable success.

The Yoruba healer has not been described in the literature as a mentally ill person, though some of the Yoruba healing cults consist of individuals who have been cured and thereafter participate in curing others. The healers known to me and my conversations with Yorubas about their healers gave no evidence that mental illness was a requisite. Thus as far as the groups reported here are concerned, mental illness does not appear to be venerated in these roles. If the shaman is to be considered either psychotic or hysterical it seems to require that a Western definition be given to the portion of behavior specific to shamanizing.

If not institutionalized in an esteemed role, is mental illness institutionalized in a contemptible role? Both the Yorubas and the Eskimos have a clearly defined role of witch as the human purveyor of magically evil influences. Though feared, the man or woman who is believed to use magic in this way is held in low esteem.

Is insanity or other mental illness *prima facie* evidence that a person is a witch? If one tries to answer this by identifying the people labeled *were* or *nuthkavihak* and then the people labeled witches and comparing the two groups to see how much they overlap in membership, as I did regarding the shamans, a serious problem arises. The difficulty is in identifying the witches. Unlike shamanizing, which is a public act, the use of evil magic is exceedingly secretive. I did note, however, that there was no correspondence between the group of Eskimos said to have been insane at some point in their lives and the six people named as *auvinak* (witch) by at least one Eskimo.

In the more generalized information from the Yoruba healers it was evident that insanity was often believed to result from the use of evil magic but an insane

person was rarely believed to use it against others. Thus my interpretation of whether mental illness is built into the role of witch is similar to the view presented about the role of healer. Some insane people have probably been accused of being witches, but it has been by happenstance, not because witching and insanity are considered to be the same thing and equally stigmatized.

In these regards the Eskimos and Yorubas seem to have much in common with the Zapotecs studied by Henry Selby (47, pp. 41-42). His work focuses on witchcraft as a major form of social deviance, and he interprets his information as supporting labeling ideas (48), especially the vulnerability of outsiders to labeling. He found that accusations of witchcraft are more likely to be leveled at someone outside the immediate group of kin and neighbors than at a group member. However, after "talking about deviance for months" with his Zapotec informants, Selby realized that he had no information on mental illness. He explored this topic separately and "found out that there were people who were 'crazy'" and that the condition was defined as having "something to do with the soul and was symptomized by agitated motor behavior, ataraxia, violent purposeless movement, and the inability to talk in ways that people could readily understand." Clearly, the Zapotecs have a conception of insanity, and, like Eskimos and Yorubas, they do not classify it in the same frame of reference with such norm transgressions as witching, envy, stinginess, and adultery.

Another way in which a culture might institutionalize a negative view of mental illness is through a degradation ceremony or ritual slaying, as in the case of the Melanesian social *mate*. Ceremony is a preservative of custom, and there is voluminous information on ceremonies for healing, ceremonies for effecting fertility of land, animals, and humans, and rites of passage, as well as ceremonies in which various forms of human sacrifice are carried out.

In view of the wide elaboration of customs whereby groups of people enact their negative and positive values, it is perhaps surprising that no groups seem to have developed the idea of ceremonially killing an insane person in the prime of life just because he is insane. Infanticide has sometimes been conducted when a child was born grossly abnormal in a way which might later have emerged as brain damage, and senility may have been a contributing factor in live burials. Also there is no doubt that insane people have sometimes been done away with, but that is different from ritual sacrifice. There is no evidence as far as I can determine that killing the insane

has ever been standardized as a custom. There are, on the other hand, numerous indications from non-Western data that the ceremony appropriate for people labeled mentally deranged is the ceremony of healing (34, 36, 38, 43). Even the word "lunatic" associates the phenomena with healing, since it was usually the healer who was believed to have power over such cosmic forces as the lunar changes which were thought to cause insanity.

Regarding informal behavior and attitudes toward the mentally ill it is difficult to draw conclusions, because there is evidence of a wide range of behaviors that can be conceptualized as audience reactions. Insane people have been the objects of certain restrictive measures among both the Eskimos and the Yorubas. The Eskimos physically restrain insane people in violent phases, follow them around, and force them to return home if they run away; and there is one report of an insane man's being killed in self-defense when, after killing several dogs, he turned on his family. In describing the Chukchee, a Siberian group known to these Bering Strait Eskimos, Waldemar Bogoras reports the case of an insane woman who was tied to a pole during periods of wildness (49). Teicher describes, in addition to the coffin-like box mentioned earlier, the use of an igloo with bars across the opening through which food could be passed (36). This is again similar to Selby's observations of Zapotecs who barred the door of a bamboo hut as a way of restraining a psychotic man (47).

The Yoruba healer of *were* often has 12 to 15 patients in custody at one time. Not infrequently he shackles those who are inclined to run off, and he may use various herbal concoctions for sedation. In Nigeria, where population is much denser than in the arctic, it was not uncommon to see *were* people wandering about the city streets, sometimes naked, more often dressed in odd assortments of tattered clothing, almost always with long, dirt-laden hair, talking to themselves, picking up objects to save. In studying a group of such vagrant psychotics Tolani Asuni noted that they usually stayed in one locale, that people fed them generously, allowed them to sleep in the market stalls, teased them mildly or laughed at them for minor deviations, and took action to control them only if the psychotics became violent (50).

A case I encountered in Gambia illustrates the complexities of the situation and indicates that compassion and rejection are sometimes both engaged. The case is of a man, identified as insane, who lived some 500 yards outside a village. The villagers lived in thatched mud houses. The madman lived on an abandoned anthill. It was about 2.5 meters long and 1.5 meters high

and the top had been worn away to match the contours of his body (Fig. 2). Except for occasional visits to the village, he remained on this platform through day and night and changing weather. His behavior was said to have become odd when he was a young man, and when I saw him he had not spoken for years, although he sometimes made grunting sounds. In one sense he was as secluded and alienated from his society as patients in back wards are in ours. On the other hand, the villagers always put food out for him and gave him cigarettes. The latter act was accompanied by laughter, because the insane man had a characteristic way of bouncing several leaps into the air to get away from anyone who came close to him, and that was considered amusing. Once a year someone would forceably bathe him and put new clothes on him.

If one defines intolerance of mental illness as the use of confinement, restraint, or exclusion from the community (or allowing people to confine or exclude themselves), there does not appear to be a great deal of difference between Western and non-Western groups in intolerance of the mentally ill. Furthermore, there seems to be little that is distinctively cultural in the attitudes and actions directed toward the mentally ill, except in such matters as that an abandoned anthill could not be used as an asylum in the arctic or a barred igloo in the tropics. There is apparently a common range of possible responses to the mentally ill person, and the portion of the range brought to bear regarding a particular person is determined more by the nature of his behavior than by a preexisting cultural set to respond in a uniform way to whatever is labeled mental illness. If the behavior indicates helplessness, help tends to be given, especially in food and clothes. If the behavior appears foolish or incongruous (in the light of the distinctive Eskimo and Yoruba views of what is humorous), laughter is the response. If the behavior is noisy and agitated, the response may be to try to quiet, sometimes by herbs and sometimes by other means. If the behavior is violent or threatening, the response is to restrain or subdue.

The answer to the question posed at the beginning of this section seems to be that the patterns these groups label mental illness (*were* or *nuthkavihak*) are not evaluated in either a starkly positive or starkly negative way. The flavor and variability of the audience reactions to mental illness suggest the word "ambivalence." Two recent studies in the United States also indicate that stigma is not automatically and universally applied to mental illness and that complex responses are typical in our society as well (51).

Norm Violations

If these Eskimos and Yorubas are ambivalent about mental illness, do they strongly condemn any behaviors at all? Both groups have words for theft, cheating, lying, stinginess, drunkenness, and a large number of other behaviors which they consider to be specific acts of bad conduct. These, like the practice of witchcraft, are thought of as transgressions against social standards and are negatively sanctioned.

In addition, the Eskimos have a word, *kunlangeta*, which means "his mind knows what to do but he does not do it." This is an abstract term for the breaking of many rules when awareness of the rules is not in question. It might be applied to a man who, for example, repeatedly lies and cheats and steals things and does not go hunting and, when the other men are out of the village, takes sexual advantage of many women—someone who does not pay attention to reprimands and who is always being brought to the elders for punishment. One Eskimo among the 499 was called *kunlangeta*. When asked what would have happened to such a person traditionally, an Eskimo said that probably "somebody would have pushed him off the ice when nobody else was looking." This suggests that permissiveness has a limit even in a cultural group which in some respects, such as attitude toward heterosexual activity, is very lenient. The Yorubas have a similarly abstract word, *arankan*, which means a person who always goes his own way regardless of others, who is uncooperative, full of malice, and bullheaded.

There are parallels between *kunlangeta* and *arankan* and our concept "psychopath"—someone who consistently violates the norms of society in multiple ways. Also, some of the specific acts of wrongdoing which Eskimos and Yorubas recognize might in our society be called evidence of "personality disorders." In Western psychiatry, this term refers to sexual deviations, excessive use of drugs or alcohol, and a variety of behaviors that primarily cause trouble for other people rather than for the doer.

It is of considerable interest that *kunlangeta* and *arankan* are not behaviors that the shamans and healers are believed to be able to cure or change. As a matter of fact, when I pressed this point with the Yoruba healers they specifically denied that these patterns are illness. Both groups, however, believe that specific acts of wrongdoing may make an individual vulnerable to illness or other misfortune. For example, Eskimos hold to a hunting ethic which prescribes ownership and sharing of animals; cheating in reference to the hunting code is thought of as a potential cause of physical or mental illness. The social codes among the Yorubas are somewhat different, but they also believe that breaking taboos can cause illness. It has been recognized by anthropologists for nearly half a century that among peoples who believe in magic there is remarkable similarity in the explanations of illness, and that transgression as well as witchcraft ranks high in the accepted etiology of many non-Western groups (52). Believing that transgression causes illness is nevertheless quite

different from believing that transgression is illness.

Thus the answer to the question of this section appears to be that these groups do have strong negative sanction for a number of behaviors. A difference between their opinions and those embodied in Western psychiatry is that the Eskimos and Yorubas do not consider these transgressions symptomatic of illness or responsive to the techniques used for healing.

Prevalence

Is the net effect of a non-Western way of life such that fewer people suffer from something they label mental illness than is the case in the West? In view of the focus on *were* and *nuthkavihak*, attention will mainly be directed to this pattern of behavior and it will be compared with schizophrenia.

There are available now a number of epidemiological studies of mental illness in different countries and cultures. Warren Dunham has compared prevalence rates for schizophrenia from 19 surveys in Europe, Asia, and North America; Table 1 is adapted from tables he presents (53). Like several others who have studied these figures, Dunham concludes that the prevalence rates "are quite comparable" despite the fact that some are based on hospital data and some on population surveys, despite differences in definitions and methods, and despite the cultural variation involved.

The rates of *were* and *nuthkavihak* can be compared to rates of schizophrenia in two Western surveys, one in Sweden and one in Canada. The Swedish study was carried out by Erik Essen-Möller and colleagues in two rural parishes for which a population register existed. Each member of the population was interviewed by a psychiatrist. A prevalence rate of schizophrenia is reported, with figures for cases in the community and cases in a hospital during a specific year (54). This design is similar to the one I used among the Eskimos, where a census register provided the base for determining the population, and each person was systematically described by at least one other Eskimo. Focusing on the people living in the specified year reduces the Eskimo population studied from 499 to 348.

The Canadian study, in which I was one of the investigators, was based on a probability sample of adults in a rural county (55). We designed the Yoruba study to explore the possibilities of comparing mental illness rates, and so used similar sampling procedures. The rates in these two surveys are based on compilations of interview

Table 1. Compilation of prevalence rates for schizophrenia, from Dunham (53).

Investigator	Date	Place	Population	Cases	
				No.	Rate per 1000
Brugger	1929	Thuringia, Germany	37,546	71	1.9
Brugger	1930-31	Bavaria, Germany	8,628	22	2.5
Stromgren	1935	Bornholm, Denmark	45,930	150	3.3
Kaila	1936	Finland	418,472	1,798	4.2
Bremer	1939-44	Northern Norway	1,325	6	4.5
Sjogren	1944	Western Sweden	8,736	40	4.6
Böök	1946-49	Northern Sweden	8,931	85	9.6
Fremming	1947	Denmark	5,500	50	9.0
Essen-Möller	1947	Rural Sweden	2,550	17	6.6
Mayer-Gross	1948	Rural Scotland	56,000	235	4.2
Uchimura	1940	Hachizo, Japan	8,330	32	3.8
Tsugawa	1941	Tokyo, Japan	2,712	6	2.2
Akimoto	1941	Komoro, Japan	5,207	11	2.1
Lin	1946-48	Formosa, China	19,931	43*	2.1
Cohen and Fairbank	1933	Baltimore, U.S.	56,044	127	2.3
Lemkau	1936	Baltimore, U.S.	57,002	158	2.9
Roth and Luton	1938-40	Rural Tennessee, U.S.	24,804	47	1.9
Hollingshead and Redlich	1950	New Haven, U.S.	236,940	845†	3.6
Eaton and Weil	1951	Hutterites, U.S.	8,542	9*	1.0

*Inactive as well as active cases.

†Cases treated six months or more.

data with selected respondents as well as systematic interviews about those respondents with local physicians in Canada and local village headmen in Nigeria.

The results of comparing these studies is that the proportion of people who exhibited or had at some time exhibited the pattern of behavior called schizophrenia, *were*, or *nuthkavihak* appears to be much the same from group to group (Table 2). At the time these studies were carried out, mental hospitals existed all over the world. The Canadian and Swedish populations are similar to the United States in having a sizable number of large mental hospitals. The Eskimo population was considered to be in the catchment area served by a mental hospital in the United States, and the Yoruba villages were in the vicinity of two mental hospitals (56). For the Canadian and Yoruba studies we do not know the number of people who might otherwise have been in the communities but were hospitalized during the period when prevalence was surveyed. The Swedish and Eskimo studies, by virtue of starting with census registers, provide information on this point. The age-adjusted prevalence rate in the Swedish survey is 8.1 per 1000 when hospitalized schizophrenics are included and the Eskimo rate of *nuthkavihak* is increased to 8.8 when the one hospitalized case is added.

The number of schizophrenics, *were*, and *nuthkavihak* in a population is small, but this comparison suggests that the rates are similar. With a broader definition of mental illness which I have explained elsewhere (it includes the neurotic-appearing symptoms, the senile patterns, and so on) the total prevalence rates for the three groups I have studied are: Canadian, 18 percent; Eskimo, 19 percent; and Yoruba, 15 percent (57).

The answer to the last question above seems thus to be that the non-Western way of life does not offer protection against mental illness to the point of making a marked difference in frequency. The rates of mental illness patterns I have discussed are much more striking for similarity from culture to culture than for difference. This suggests that the causes of mental illness, whether genetic or experiential, are ubiquitous in human groups.

Summary and Conclusions

Labeling theory proposes that the concept of mental illness is a cultural stereotype referring to a residue of deviance which each society arbitrarily defines in a distinct way. It has been assumed that information from cultures that are markedly different from Western society supports

Table 2. Rates of nonhospitalized schizophrenia in two Western samples and of indigenously defined insanity in two non-Western samples. Rates are per 1000 population after adjustment by the Weinberg method (58).

Group	Date	Size	Cases	
			No.	Rate per 1000
Swedish	1948	2550	12	5.7
Eskimo	1954	348	1	4.4
Canadian	1952	1071	7	5.6
Yoruba	1961	245	2	6.8

the theory. This paper presents systematic data from Eskimo and Yoruba groups, and information from several other cultural areas, which instead call the theory into question.

Explicit labels for insanity exist in these cultures. The labels refer to beliefs, feelings, and actions that are thought to emanate from the mind or inner state of an individual and to be essentially beyond his control; the afflicted persons seek the aid of healers; the afflictions bear strong resemblance to what we call schizophrenia. Of signal importance is the fact that the labels of insanity refer not to single specific attributes but to a pattern of several interlinked phenomena. Almost everywhere a pattern composed of hallucinations, delusions, disorientations, and behavioral aberrations appears to identify the idea of "losing one's mind," even though the content of these manifestations is colored by cultural beliefs.

The absence of a single label among Eskimos and Yorubas for some of the phenomena we call mental illness, such as neuroses, does not mean that manifestations of such phenomena are absent. In fact they form a major part of what the shamans and healers are called upon to treat. Eskimos and Yorubas react to people they define as mentally ill with a complex of responses involving first of all the use of healing procedures but including an ambivalent-appearing mixture of care giving and social control. These reactions are not greatly dissimilar from those that occur in Western society. Nor does the amount of mental illness seem to vary greatly within or across the division of Western and non-Western areas. Patterns such as schizophrenia, *were*, and *nuthkavihak* appear to be relatively rare in any one human group but are broadly distributed among human groups. Rather than being simply violations of the social norms of particular groups, as labeling theory suggests, symptoms of mental illness are manifestations of a type of affliction shared by virtually all mankind.

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42. Gussow (40) provides a description of *pibloktoq* based on 14 recorded cases, mainly from explorers and ethnographers in the area from Greenland to the west coast of Alaska during the first part of this century. Recently a serious attempt was made to study *pibloktoq* properly and measure its prevalence. Ten cases were located from a population of 11,000 Inuit Eskimos. These cases were found on further study to be exceedingly heterogeneous: "Several subjects had epilepsy; several were diagnosed as schizophrenic; most had low normal serum calcium levels; one had hypomagnesemia and possible alcoholism" [E. Foulks, *The Arctic Hysterias of the North Alaskan Eskimo* (American Anthropological Association, Washington, D.C., 1972), p. 117]. This information suggests that *pibloktoq* is and may always have been a rare and ill-defined phenomenon. Regarding *wittiko* my assessment of the evidence is similar to Honigsmann's when he says, "I can't find one [case] that satisfactorily attests to someone being seriously obsessed by the idea of committing cannibalism" (18, p. 401).
43. M. Beiser, J. Ravel, H. Collomb, C. Egelhoff, *J. Nerv. Ment. Dis.* 155, 77 (1972); M. Micklin, M. Durbin, C. Leon, *Am. Ethnol.* 1, 143 (1974); H. Kitano, in *Changing Perspectives in Mental Illness*, S. Plog and R. Edgerton, Eds. (Holt, Rinehart & Winston, New York, 1969), p. 256; R. Edgerton, *Am. Anthropol.* 68, 408 (1966); the following in *Magic, Faith, and Healing*, A. Kiev, Ed. (Free Press of Glencoe, New York, 1964): S. Fuchs, p. 121; K. Schmidt, p. 139; M. Gelfand, p. 156; B. Kaplan and D. Johnson, p. 203; M. Whisson, p. 283.
44. J. Murphy and A. Leighton, in *Approaches to Cross-Cultural Psychiatry*, J. Murphy and A. Leighton, Eds. (Cornell Univ. Press, Ithaca, N.Y., 1965), p. 64.
45. A. Rose, in *Human Behavior and Social Processes*, A. Rose, Ed. (Houghton Mifflin, Boston, 1962), p. 537.
46. Western society also lacked a comprehensive concept of neurosis prior to Freud's influence, but at the present time neurotic patterns hold a firm position in the official classifications of Western psychiatry; see *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, Washington, D.C., 1968).
47. H. Selby, *Zapotec Deviance, The Convergence of Folk and Modern Sociology* (Univ. of Texas Press, Austin, 1974).
48. Much of the support for labeling theory which Selby finds in his evidence stems from the following statement: "To the villagers, witches have an objective reality 'out there'. To me, they do not. I, the sociologist-anthropologist, do not believe that there are people in the world who have the capacity to float foreign objects through the air, insert them into my body, and make me sick or kill me" (47, p. 13). He concludes, "We create the deviants; they are products of our minds and our social processes." It seems to me this is a mistaken conclusion. I agree that the people who use witchcraft do not actually kill their victims by their incantations, burning effigies, boiling nail parings, and so on. The question, however, is whether some people actually carry out these maliciously intended acts. My work with Eskimos and Yorubas suggests that the idea of witchcraft is widely available to these groups just as the idea of lethal weapons is to us and that a few people in such groups really do conduct the rites that they believe will harm others (the artifacts of witchcraft attest to this), that they are genuinely deviant in these practices, and that they are the brunt of strong disapproval because of them. In this regard witchcraft involves real acts. It just happens that because these acts are by definition secret they give rise to distortions, false accusations, and misidentifications.
49. W. Bogoras, in *The Jesup North Pacific Expedition*, F. Boas, Ed. (Memoir of the American Museum of Natural History, New York, 1904-1909), p. 43.
50. T. Asuni, in *Deuxième Colloque Africain de Psychiatrie* (Association Universitaire pour le Développement de l'Enseignement et de la Culture en Afrique et à Madagascar, Paris, 1968), p. 115.
51. W. Bentz and J. Edgerton, *Soc. Psychiatr.* 6, 29 (1971); H. Spiro, I. Siassi, G. Crocetti, *ibid.* 8, 32 (1973).
52. F. Clements, *Primitive Concepts of Disease* (Univ. of California Publications in American Archaeology and Ethnology, Berkeley, 1932).
53. W. Dunham, *Community and Schizophrenia, An Epidemiological Analysis* (Wayne State Univ. Press, Detroit, 1965), pp. 18, 19. Dunham indicates that 21 cases of schizophrenia were discovered in the Essen-Möller study. I use 17 of these (those for whom the author had high confidence that the pattern was schizophrenia). For comparability between Tables 1 and 2, I recalculated the rate for this one study. See also T. Lin, *Psychiatry* 16, 313 (1953), for a similar use and interpretation of several of the studies cited here.
54. E. Essen-Möller, *Individual Traits and Morbidity in a Swedish Rural Population* (Ejnar Munksgaard, Copenhagen, 1956). The rates for schizophrenia in the community and in the hospital were calculated from information on pp. 85-86.
55. A. Leighton, *My Name is Legion* (Basic Books, New York, 1959); D. Leighton, J. Harding, D. Macklin, A. Macmillan, A. Leighton, *The Character of Danger* (Basic Books, New York, 1963).
56. T. Lambo, in *Magic, Faith, and Healing*, A. Kiev, Ed. (Free Press of Glencoe, New York, 1964), p. 443; T. Asuni, *Am. J. Psychiatry* 124, 763 (1967).
57. J. Murphy, in *Transcultural Research in Mental Health*, W. Lebra, Ed. (Univ. Press of Hawaii, Honolulu, 1972), p. 213.
58. W. Weinberg, *Arch. Rassen. Gesellschaftsbiol.* 11, 434 (1915). The Weinberg method of adjusting the rate of mental illness for the probable age period of susceptibility is useful when the age distributions of the populations compared are different. Comparison of Western and non-Western populations particularly need such adjustment. The age of susceptibility for schizophrenia is assumed by Weinberg to be 16 to 40 years; I used 20 to 40 years because that age breakdown is available in the four studies compared.
59. The Eskimo and Yoruba studies which form the core of this paper, and the Canadian study used for comparison, have been carried on as part of the Harvard Program in Social Psychiatry directed by Alexander H. Leighton and supported by funds from the Social Science Research Center of Cornell (for the Eskimo studies), the National Institute of Mental Health, the Ministry of Health of Nigeria, and the Social Science Research Council (for the Yoruba studies), the Carnegie Corporation of New York, the Department of National Health and Welfare of Canada, the Department of Public Health of the Province of Nova Scotia, the Ford Foundation, and the Milbank Memorial Fund.