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Culture and Mental Illness: A Social Labeling Perspective

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The implementation of the notion that sociocultural factors play a significant role in the etiology and course of mental disorders requires the formulation of theories explaining and articulating the processes involved. This is also necessary for substantiating and guiding decisions aimed at improving individual patient care and public health.

An example of such a theory is proposing that social change has a causative role in pyschopathology, as suggested by Leighton (1959) and many others. This role may be quite different in regard to the severe psychoses versus the milder neurotic and adjustment disorders (see part V). Another example is labeling or social response theory. Some interpretations of this theory have been directed to the explanation of the development of mental disorders and this sometimes in a narrow light, excluding the participation of psychobiological factors. Alternative interpretations, such as that cogently discussed by Waxler in the following paper, are convincingly applied to the explanation of course and outcome of illness and quality of patienthood.

OBSERVATIONS MADE by the author in Ceylon (now known as Sri Lanka) and by many practitioners in Africa suggest that the serious psychoses one sees in these peasant systems are of short duration with an excellent prognosis. One systematic study that followed treated schizophrenic patients in the peasant villages of Mauritius has shown that clinical symptoms and social performance after 12 years are significantly better than a comparable group of patients in Great Britain even though the Mauritian treatment was considerably more limited.

Several theories have been developed to explain these kinds of cross-cultural differences in types, rates, and outcomes. Leighton has tied cultural differences to social change, suggesting that more mental illness may occur in rapidly changing societies undergoing industrialization or modernization. Others have suggested that the apparent quick recovery in peasant societies is due to their greater tolerance for deviation. Some have suggested that cross-cultural differences in rates and prognosis are explained by poor epidemiological methods in the peasant societies; the illnesses are there but simply are not counted.

We propose an alternate theory that we feel may better explain the facts. Societies do not cause different rates of mental disorder nor tolerate different degrees of deviance; instead they respond differently to psychiatric illness once it occurs. Differences in societal response, in turn, account for differences in rates and outcome. The social labeling theory of deviance provides concepts and hypotheses that help to explain how different societies may succeed in molding the mentally ill person to match societal expectations.

Of greatest importance in this process are the belief systems of the society and the extent to which the patient has power over his own role as a sick person. In societies such as Ceylon and Mauritius, where beliefs about mental illness center on supernatural causation, where the person is not held responsible for his illness, where his "self" remains unchanged, he can shed the sick role quickly and easily. In contrast, where psychiatric illnesses are believed to involve personality change and personal responsibility, the sick person receives many messages that something is seriously wrong with his self; his self-perception and behavior may conform to these messages and his illness may have a long duration.

The nature of the treatment system, too, may contribute to the patient's outcome. In peasant societies where treatments are highly ritualized and where practitioners are not bureaucratically organized, patients and their family retain control over illness-confirming messages, and the patient may easily drop the sick role and return to "normality." In many Western societies, treatment systems are both comprehensive and bureaucratic, the patient may become engulfed in this system and find little reward and little opportunity for shedding the sick role.

Thus, how societies process the mentally ill person once the illness has been recognized may be a crucial factor in explaining cross-cultural differences in the rates of and prognosis for psychiatric disease.

While studying psychiatric treatments in Ceylon I was surprised by the large number of families reporting that their patient, after having been treated briefly by native and/or Western methods, was now "cured." Further investigation indicated that these judgments were probably valid; after a brief episode of mental illness most patients were able to return quickly and easily to their normal roles (Waxler, In Press).

My observation that psychiatric disease in Ceylon is of brief duration and leaves few residual symptoms is echoed by those who have had experience with mental illness in other primitive and peasant societies. For example, reporting from Africa, German has observed that "acute transient psychoses, characterized by gross disruption of mental function and with an excellent prognosis, are the most common types of psychotic states seen in African hospital practice" (1972:465; see also Tewfik 1958; Jelik and Jelik 1970). The same phenomenon has been reported by Rin and Lin (1962) in an aboriginal group on Taiwan and by others working in quite different peasant cultures. In peasant societies, psychiatric illnesses, at least those that come to the attention of Western doctors, seem to be brief, perhaps florid, but generally the patient returns easily to live in the village.

What accounts for these observations, that in a peasant society like Ceylon the patient who has suffered a psychosis can so easily and quickly return to normal? My thoughts followed these lines. Traditional Ceylonese beliefs about mental illness center upon supernatural causes—demon possession, witchcraft, bad influence of the planets; if a person is supernaturally affected he can be easily treated by prescribed standard rituals carried out by exorcists and priests. The sick person, himself, is not believed to be responsible for the illness; his body or soul may be possessed but his "self" remains unchanged. If he follows the appropriate prescriptions, then it is believed that his symptoms will disappear and he will quickly and easily return to normal. There is no stigma attached to mental illness; no one believes that the patient is "different" and should be treated in a new way after his symptoms have gone. Thus, the way people formulate the illness calls forth certain societal expectations and responses which, in the Ceylonese case, seem to allow the patient to drop the sick role quickly and easily.

This hypothetical explanation of the high rate of cure of mental illnesses in Ceylon focuses upon the beliefs the society holds about mental illness and the consequent response of the society to the person once his symptoms have been noticed. Comparative social psychiatric work, however, has traditionally explained cultural differences in rates and outcome of illness in quite different terms. The most developed and complete formulation that seeks to explain why psychiatric diseases vary in type and incidence across cultures links the incidence of mental illness to social change. Leighton (1959) has suggested that rapid social change results in social disequilibrium and disintegration; when such change occurs there may be, for example, increasing proverty, cultural confusion, secularization, high frequency of broken homes, few and weak leaders, and fragmented networks of communication. These, in turn, may result in alienation, unmet personal needs and higher rates of mental illness in those who cannot or do not "fit" into the new society. Thus, as societies shift, under economic and other pressure, from traditional village systems to urbanized and industrialized systems, more people come to be "at risk" for psychiatric disease. Social disequilibrium, through an intervening process of disrupted personal needs, causes mental illness.

If the social causation theory were to be confirmed empirically we would expect to find that the incidence of psychiatric disease varies with the degree of social disintegration or the amount of rapid social change occurring in the societies compared. Yet the few cross-cultural epidemiological studies meeting requirements of sound methodology have shown that the incidence of the most common psychosis, schizophrenia, may be very much the same in all societies (Lin 1953); problems of methodology and theory prevent any clear statement about the incidence of other types of mental illness (Dunham 1965). Leighton shows that prevalence of mental illness is similar in the Yoruba of Africa and the Canadians of Nova Scotia (Leighton et al. 1963), although there are some tendencies for the more socially "disintegrated" areas of each group to have higher rates. See Kunitz's (1970) critique of the Stirling County study for further analyses of Leighton's findings. However, from these and other studies it is not at all clear that rapidly industrializing and modernizing societies, in contrast to the traditional unchanging peasant and primitive societies, create more mental illness.

A second explanation offered by comparative social psychiatrists for the different rates and outcomes of psychiatric disease in peasant and modern societies is that cultures vary in terms of the amount of deviation they will tolerate. For example, they would argue that the reason I saw so many patients who were "cured" in Ceylon was simply that the range of normal behavior is much wider than it is in the West; a patient who returns to his home may continue

to hear voices but this is not deemed to be an indicator of sickness if he, at the same time, can plow the paddy fields. In Western societies, behavior must meet higher standards in order for the patient to be judged cured. This assumption that peasant and primitive societies allow greater laxity in behavior does not fit with my own observations in Ceylon and may be a carry-over from the "carefree savage" days when observers, looking into the peasant society, failed to see the complexity of the normative system. Until there is more empirical evidence (particularly, the incidence of untreated mental illness in the community), the argument that peasants tolerate more deviance than modernized people, thus accounting for the different outcome of psychiatric illnesses, remains unsubstantiated.

Finally, many comparative social psychiatrists, especially those who have attempted epidemiological research in underdeveloped societies, would argue that the reason for findings showing more short-term illnesses and higher cure rates in peasant societies is a methodological one. If surveys were as complete and controlled as say, the Myers and Bean (1968) study in New Haven, one would find much more evidence of psychiatric illness, in Africa or Ceylon, or elsewhere. In other words, the more carefully you look for it the more mental illness you will find. These people would suggest that construction of social psychiatric theories on the basis of most current epidemiological data is fruitless unless and until we can be certain that reported rates accurately reflect the "real" rates of illness in the community.

Each of the above explanations for differences in rates and outcome of mental illness has a certain plausibility, yet none has very strong empirical support. We propose an alternate explanation. Societies do not *cause* different rates of mental disorder nor tolerate different degrees of deviance; instead they do *respond* differently to psychiatric illness once it occurs. Differences in societal response, in turn, account for differences in types of illness and outcome.

Briefly, many peasant societies, like the Ceylonese, do not "make much" of mental illness. Beliefs center on external causation, treatments are routinized, and there is no stigma. When a person becomes ill he is believed to remain basically unchanged as a person. Families, acting on the basis of these societal beliefs, give explicit and implicit messages to the patient that reinforce the normal role. Treatment agents, too, because of their lack of bureaucratic organization as well as the content of their messages confirm the societal expectations. Thus, the sick person is most likely to fulfill these expectations by returning quickly to "normality."

In contrast, in many industrialized societies, when mental illness appears the response of family and those who will treat the patient is to perceive the sick person as now "different." He is often socially rejected; he is encouraged or required to seek treatment (to take the "sick role"); and he may be engulfed in a bureaucratic treatment system in which he has little power to resist illness-confirming messages. Again, the sick person may often fulfill the expectations that others have for him; in this case, however, the messages confirm "sickness."

In presenting brief summaries of these alternative theories we have deliberately not distinguished between different types of mental illness, assuming that the tolerance of deviance notion, for example, applies equally well to patients diagnosed as schizophrenic as it does to those with minor neuroses. With the exception of Murphy and Leighton's work (1965), where there has been concern with examining specific psychiatric syndromes cross-culturally, theories explaining cultural differences in patient careers have usually not been tested empirically at a level at which it was necessary to refine predictions for types of psychiatric syndromes. This is true of the social response theory as well; its current use is to describe the careers of "the mentally ill." One would expect that as empirical work proceeds the theory will be refined to predict the efforts of social responses on those with schizophrenic disorders, alcohol addiction, patients with depressive symptoms, etc. We might expect, for example, that the contribution of society's responses to the patient's career is relatively great for the neuroses and perhaps more limited for the severe psychoses.

Labeling Theory: A Social Response Explanation of Cultural Differences

The interpretive model that we have introduced to explain the different experiences of the mentally ill in Ceylon and in Western societies comes from a more general sociological theory called "social response" or "labeling theory" (Lemert 1967; Scheff 1966b; Schur 1971). Labeling theory, we feel, provides concepts and hypotheses that are extremely useful in explaining how different cultures turn out psychiatrically ill people who follow radically different patient careers. We shall introduce some of the more important assumptions of the theory, some of the concepts and hypotheses, and then show how they might be useful in cross-cultural analyses.

Labeling theory concerns itself with the effects of social experience upon a sick person (or any other deviant) once the illness has occurred—that is, with the processes through which the society labels him as "sick." The theory, thus, alerts us to what happens to a person after his symptoms appear. As we have pointed out, this approach is quite different from past social psychiatric theory where concern was with social factors that contributed to the etiology of mental illness. There the focus was on the patient's social background, his position in the community network, or his commitment to the social norms which were, in turn, assumed to be social correlates of psychological factors (such as unmet personal needs or stress) that *caused* mental illness.

In contrast, labeling theory is not interested in explaining the primary cause of the initial psychiatric illness, or "primary deviation." Whether psychiatric illness results from genetic factors, biochemical defects, certain family dynamics, or anomia is not important. What is important is how the society responds to and processes the sick person once the symptoms have occurred. In fact, it is assumed that many such symptoms appear, in many people, at one time or another; yet relatively few of these people find their way to formal treatment systems and into the sick role. The theory predicts that it is the societal response *to* the person with psychiatric symptoms that is the prime determinant of whether he will remain sick and will receive treatment. It is the societal response *to* him that will further determine whether he becomes a "secondary deviant," that is, a person whose major role identification is that of a sick person (Lemert 1967). Thus, the career of the sick person is influenced, not by biological or social factors in his past that cause severe or mild symptoms, curable or noncurable illnesses, but by the ways his family, his neighbors, and most significantly, his doctors respond to him once any sort of symptom occurs.

It is apparent from the vocabulary of labeling theory that illness is seen as something more than just bodily symptoms and personal discomfort. The theory conceives of psychiatric illness as one form of deviation from the social norms; in other words, the sick person has taken on a sick role because he is unable to carry out his normal role obligations. He is unable to work, to go to school, to do what is expected of him as a father or son, for example. These social role disabilities, from the point of view of labeling theory, are the crucial qualities of illness. Bodily symptoms are, of course, not denied importance, but a conceptual distinction is made between clinical diagnosis and social role since it is quite apparent that some clinically ill people are never defined by anyone as being sick and some sick people have few, if any, clinical symptoms.

We have followed this conception of "outcome" of mental illness throughout this paper. That is, we assume that both the patient's clinical symptoms and his ability to carry out his normal social roles are significant for his career as a sick person. However, measures of symptoms at a specified follow-up point are not simply substitutes for measures of role performance since the two factors, following the social response model, are not necessarily highly correlated. Thus, following Brown's example (Brown et al. 1966), we might include as indicators of outcome the presence of delusions, hallucinations, the extent to which these are socially disturbing, as well as whether the person can hold a job, care for children, and get along with family and neighbors. The evaluation of social disturbance, getting along with others, is based on the norms of the patient's own society.

Then, how do the responses of people in a society to a sick person model and sustain that sickness? Once a person is recognized by his family or others as having symptoms of an illness, certain negotiations begin between interested parties as to the patient's status (Balint 1957). Families discuss among themselves and with the patient "what is wrong" and "what is to be done about it." Treatment people also negotiate with the patient and family about the same issues. Once the idea of mental illness is introduced the process becomes one in which all parties begin to introduce subtle expectations into their messages to the patient about *how* he should behave as a sick person (Scheff 1966b). Being mentally ill in the normative or proper way is convenient for all concerned since it makes future interactions predictable and smooth. Thus both families and treatment people may give explicit and implicit messages to the patient that he is, indeed, mentally ill, they expect that he will behave according to the appropriate model of mental illness, and they will reward him for so doing.

What does the sick person do, then, when he receives such messages? When a person with symptoms of mental illness finds himself in what is most often a new and frightening situation, he looks around himself for confirmation and guidance. This search for self-definition is most apparent when the patient has, for example, little information, few alternative roles, low power, and when he receives few messages that disconfirm his illness. Under these conditions he begins to take the sick role; that is, he models his behavior on the expectations of other important people—treatment agents and family—with whom he interacts. They, in turn, have modeled their expectations on beliefs about mental illness in the common culture and their own experiences with such illness.

that supports this argument. Then we shall demonstrate how two important aspects of social response theory—the society's system of beliefs and the structure of its treatment system—can be used to understand differences in the social processing of and thus the treatment outcome for mentally ill people in peasant and modern societies.

Social Response as an Explanation for Clinical and Social Outcome in Two Societies

Recently H. B. M. Murphy and Raman (1971) and Raman and Murphy (1972) reported research designed to examine the observations many people have made, that peasant societies in Africa and elsewhere seem to produce psychotic patients whose prognoses are much better than in the West.[2] Their findings and some of their interpretations lend considerable support to a social response explanation of cross cultural differences.

We shall review these findings very briefly, touching only on issues important in illustrating the theoretical model; readers interested in details of method should consult the original study. Their data came from a 12-year follow-up of psychiatric patients originally treated at the only government psychiatric hospital on the island of Mauritius, an independent state in the Indian Ocean. The Mauritian society is a peasant one, based on a one-crop sugar cane economy; two thirds of the population is Indian and one third African. Although the degree of Westernization is quite limited, British and French colonial control left Mauritius with a psychiatric hospital having the same relative capacity as those in Great Britain. At the time of the study, however, treatment was limited to insulin coma and electric shock; there were no phenothiazines, no psychotherapy, and no aftercare clinics.

A cohort of 94 first admission schizophrenic patients admitted to the hospital in 1956 was followed up 12 years later by home visits. Nurse-interviewers obtained information about course of symptoms and the social performance of patients since discharge. Findings from Mauritius where compared with a follow-up study of schizophrenic patients discharged from three psychiatric hospitals in England. The latter research, carried out by Brown et al. (1966) used similar sampling methods, and obtained similar data from the patient and his family, although the follow-up period was 5 instead of 12 years.

2. The discussion in this section refers only to schizophrenic patients followed after their first hospital admission.

Our first concern is with the incidence of schizophrenia in the two cultures, the peasant society of Mauritius and the industrial society of Great Britain. Murphy and Raman show that treated age-specific rates of schizophrenia are very similar in the two cultures. Further, the symptoms of patients diagnosed on admission as schizophrenic on Mauritius appear to be no different from symptoms found in schizophrenics in Great Britian.

At the point of entrance into treatment, then, the two societies begin with quite similar characteristics; incidence rates for and types of symptoms of schizophrenic patients are similar. What happens to the patients? Almost all of the findings support the conclusion that clinical and social outcome for treated schizophrenia is better in the peasant society of Mauritius than in Great Britain. In the Mauritian sample 62 percent (or 55 of the total of 86 patients) were classified as being "socially independent with no symptoms" at follow-up; the comparable proportion classified in the same way in the English sample was significantly lower, 49 percent (or 49 out of a total of 100 followed patients). Similar differences between societies were found when the total course of the patient's disorder since the original hospitalization was measured. More Mauritian schizophrenic patients (59 percent of the sample) were able to leave the hospital and return quickly and easily without any further symptoms or treatments to their jobs or household chores. In contrast, fewer (45 percent) British patients were classed as having "no disturbance" or being "symptom-free in the past year." It is interesting to note that the social and clinical outcome differences come largely from the group of patients who do *not* remain chronically ill; 36 percent of the Mauritian sample (32 patients) and 28 percent of the English sample (28 patients) are classified as "chronically disturbed" (in the British study) or having "continuous total or partial disability" or "several episodes of nonfunctioning" (in the Mauritian study). Thus, although rates of chronicity are quite similar, the careers of the nonchronic patients in Mauritius and Great Britain vary. Although psychiatric treatment is admittedly less modern in Mauritius than it is in Great Britain, the outcome for the nonchronic schizophrenic patient in Mauritius is considerably better. Quick return to normality for many patients in this peasant society is assured; the same is not true for similar patients in England.

The social response model suggests an explanation for this set of facts. In fact, Murphy and Raman imply this interpretation when they suggest that the nonchronic English patient "may be 'trapped' within an established sick role by the superficial rationality of society's view of this 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" (H. B. M. Murphy 1972:496). On Mauritius mental illnesses are often attributed to supernatural causes, to demons or ghosts that attack at random; the patient is not believed to be responsible nor to be changed in any basic way.[3] Thus, once acute symptoms disappear; i.e., once the supernatural effect has gone, families, neighbors, and treatment people expect that the patient will return to normal; in the face of these expectations the majority of sick people may comply. Further, patients may retain considerable control over how long they retain the sick role since treatment bureaucracies are in their infancy in Mauritius. No one makes home visits; no patient is required to return regularly for outpatient treatment; no local village authority is given responsibility for the patient once he returns home. Thus, few structural supports exist within the treatment system to maintain the sick role beyond the point of hospital discharge. The contrasts with beliefs and treatment systems in Great Britain should be quite apparent.

We have presented the Mauritian data and English comparison data in some detail in order to make concrete the utility of the social response mode. Naturally, we would want more information about Mauritian beliefs and native treatments in order to substantiate the interpretation we have made; further, the findings might be understood in alternate ways. However, the data lead us to the conclusion that the incidence of treated schizophrenia in these peasant and industrial societies is probably the same, yet the outcome for the treated patient is different, even though Mauritian hospital treatments are not as modern as in England. Social and clinical outcome may be dependent upon the response of the society to the sick person, and two response factors are particularly important. First, the cultures differ in beliefs about the cause of mental illness, appropriate treatments, and the proper ways for sick people to take the sick role. Second, these beliefs may have led to reliance on specific types of treatment systems. The comprehensive, integrated and highly available treatment bureaucracies in Great Britain may have latent functions that serve to maintain the patient in the sick role once his illness is recognized. Treatment systems like those in Mauritius that are organizationally isolated and not readily available may allow for easy return to normality.

3. Personal communication, from Dr. A. C. Raman, Brown-Sequard Hospital, Mauritius, 1973.

Impact of beliefs on the sick role. While it would be commonly agreed that beliefs about an illness are in some way important for the sick person, social response theory directs our attention to ways in which and places in which these beliefs have their impact. Thus, once a person with symptoms is defined as sick, a series of negotiations begins between him and other interested parties such as families and treatment people. The messages that they give to the patient about how to be sick are representative of the beliefs about illness that are commonly held in the society. Thus, to see the importance of the belief system on the patient's career in different cultures we should examine these negotiation processes.

In our own Western society, it is a common and acceptable belief that once a person has a serious mental illness like schizophrenia he is "changed" for life; he may, in fact, always be schizophrenic, perhaps in a latent way. We see this in newspaper reports that attribute violent acts to former mental patients. The same belief is officially confirmed in a handbook published by the National Institute of Mental Health (1972): "a person does not *have* schizophrenia as he might have an ulcer in his stomach or a cold in his head. He *is* schizophrenic; he *is* the disorder. It pervades his entire being" (p. 5). That this expectation may be communicated from family to patient is supported by Freeman's findings (Freeman and Simmons 1958) that families who believe mental illness is incurable expect little improvement in their patient member, and their expectations are confirmed.

Further, many Westerners believe that interpersonal relationships, especially those in the past, account for later personality defects and mental disorders. We see the impact of this belief in Scheff's description of a patient–doctor negotiation in which the patient proposes several successive formulations of her illness, none of which "matches" the doctor's beliefs about mental disorder (Scheff 1968). All are rejected in subtle ways by the doctor. Not until the patient proposes a formulation that is intrapsychic and links with past interpersonal experiences does the therapist agree. At this point "the therapist's tone and manner change abruptly. From being bored, distant and rejecting, he becomes warm and solicitous. Through a process of offers and responses, the therapist and patient have, by implication, negotiated a shared definition of the situation" (Schur 1971:10). In the process the patient's model for her own mental illness is radically if subtly changed.

The negotiations between the patient and other interested people in Western societies communicate certain expectations about how to be sick in a proper way, one that conforms to the society's beliefs about such illnesses. We would expect that similar negotiations occur in peasant societies, the major difference being the quality of social expectations that are communicated to the sick person.

In many peasant societies beliefs about the prognosis for serious mental illness are in sharp contrast to Western ideas; severe psychoses are believed to be brief, curable, leaving no lasting after effects. This is certainly true for the Sinhalese villagers, and the expectation that mental illness is of short duration is communicated to the patient by native treatment people. When treating mental illnesses attributed to demon possession, the Ceylonese exorcist ties a charmed thread around the patient's wrist, and announces that the thread is protective for a limited period, a week or 3 months. It is understood that many illnesses go away within that period of time. If not, in the more elaborate and major rituals repeated announcements are made by the exorcist that the ritual itself is "conclusive," that the illness of the patient is "now over" (Obeyesekere 1969). The astrologer, to whom many psychiatric patients and their families turn, reinforces these messages by predicting the date on which the cure will be complete. Each of these public predictions acts as a powerful sanction on the patient to conform to expectations. The fact that predictions are ordinarily for short periods, usually 3 or 6 months, may serve to model mental illnesses with short durations. Certainly there is no promise of reward for a chronic sickness.

A belief that mental illness is caused by supernatural agents who often act in an irrationally vindictive way, attacking persons without reason, is common in Mauritius and Ceylon as well as many other peasant societies. The implication of this belief is that the patient cannot be "blamed" for his predicament; his sickness is thus not linked with his own past experience nor can he be expected to take on a new role. These beliefs about the cause of mental illness are also the basis for negotiation between family or treatment agent and the patient, even within what we might assume are very rigidly constructed ritual treatments. For example, Edgerton (1969) reports the process of negotiation between the family of a Tanzanian adolescent boy and a native doctor. After a ritual of divination and prayer the doctor proclaimed that the boy's illness was incurable and probably inherited. This diagnosis, unacceptable to the family, then became the central issue in a long discussion; the boy's father

gave arguments why inheritance was an unreasonable cause and finally offered an alternative, witchcraft, an acceptable belief in the society. Then, "the father offered to pay the doctor well if he could identify the witch and the malevolent witchcraft being used, could cure the boy, and then punish the witch" (Edgerton 1969:60). Both parties, having settled on witchcraft as an alternate explanation then carried on with the treatment. The boy improved and his improvement thus confirmed the agreement about the cause of the illness and the belief that cure was possible.

These examples have suggested the important part that negotiations between patients and treatment agents have in translating the society's beliefs about mental illness into concrete expectations for the patient's behavior. Social response theory predicts that the sick person is most likely to conform to these expectations, thus being sick in the way his particular society defines mental illness.

Impact of bureaucracies on the sick role. While the society's beliefs about the mental illness, transmitted in messages to the patient, are important in molding the role that a mentally ill person takes, there are certain conditions under which a patient may resist such messages. One such condition involves the power of the patient relative to the social context in which treatment is given. When the treatment system is a highly organized, integrated, and comprehensive bureaucratic structure, most sick people are powerless to resist illness-confirming messages when they receive them. On the other hand, when the treatment system is not highly structured, the patient retains more power over his patient career and may easily avoid such messages. Thus the organizational structure of treatment systems may reinforce illness, through the expectations about sickness that people in the system communicate to the sick persons.

We shall return to the data from Mauritius and Great Britain to suggest how the treatment systems themselves may model mental illness having quite different clinical and social outcomes. These data will suggest that the greater the patient's contact with treatment agents and the more integrated and comprehensive the treatment system, the poorer the social and clinical outcome for the patient. Thus the nature of the sick peasant's experience within nonbureaucratically organized treatment systems may be one important factor that explains why peasant societies produce psychiatric patients with acute illnesses and good prognosis.

Brown and his colleagues (1966) obtained their sample of first-admission schizophrenic patients from three British psychiatric hospitals. The significant factor for our analysis here is that these three

hospitals vary considerably in the extent of treatment offered. The Mapperly Hospital in Nottingham provided the most extended and diverse system of services; the hospital was developed "to form a comprehensive system of the community care intended to assist patients and their families from onset of illness until recovery or death" (Brown et al. 1966:14). Mapperly provides inpatient and day hospital care, 50 specialized outpatient sessions per week, rehabilitation centers, and vocational training. The hospital has direct links with the local town services for the mentally ill. This highly integrated treatment system is similar in goals and structure to the newer community mental health centers in the United States in that it reaches into the community to prevent illness, follows patients to their homes after hospital discharge, and services many and diverse patient needs.

In contrast, the hospitals that provided the remainder of the schizophrenic patients followed in Brown's study do not offer such extensive services. One hospital (Netherne) gives only inpatient services and has 28 outpatient clinics per week and six psychiatric social workers; other agencies with which a patient might have contact, such as the general practitioner or the local mental welfare officers, are independent of the hospital. The third hospital (Severalls) has even fewer services, only nine outpatient sessions, one social worker, and no formal attachments to other agencies. Thus the range of patient services in these two hospitals is considerably less than in the Nottingham hospital.

Although the samples of first admission schizophrenic patients followed from the three hospitals did not differ greatly from each other at the time of admission, nor was their treatment in the hospital significantly different, those patients who were followed from the Mapperly Hospital for a 5-year period after discharge "were under care in the community for about eight times as long as patients from the other two hospitals" (Brown et al. 1966:165).[4]

Thus, knowing that Mapperly Hospital provides a very integrated, available system of treatments to discharged patients, and knowing that the particular patients followed in this research received eight times as much treatment as those from the other two hospitals, we would expect that the outcome for Mapperly patients would be considerably better than for the others as well. This is not true. Measures of social performance, symptoms, and the course of the patient's illness uniformly show that the first admission schizophrenic patients discharged from the Mapperly Hospital are either not significantly different upon follow-up from those treated in the other two hospitals, or they are significantly worse; trends are almost always in the negative direction. There is no evidence, then, that what most specialists would judge to be the "best" treatment system produces the "best" outcome.

In fact, if we compare the findings from patients who are discharged from the three British hospitals with those from the Mauritius hospital, we discover that across the four treatment facilities, that is, the three hospitals in Great Britain and one on Mauritius, as the psychiatric treatment given becomes better or more modern the outcome for the patients who are treated becomes worse. The Mauritius hospital, with its limited facilities for following patients and its narrow range of medications, leads to the best outcome; the next best outcome comes, generally, from the two more limited British hospitals; tendencies for the poorest outcome come from the model community mental health center at Mapperly.

Social response theory suggests that the labeling of deviance, in the form of messages to the patient about how to conform to the sick role, is consistently strengthened and reinforced in a large bureaucratic treatment system such as Mapperly and similar Western mental hospitals. In the face of these large comprehensive organizations many patients have little power to resist such messages (Goffman 1961; Rosenhan 1973). In such hospitals staff members have little time with patients, little information about them and their actions are highly routinized. This structure leads to a conservative bias, that is, to a decision that is safe, on the part of treatment agents; for example, a continued drug prescription, further time in the hospital, or a recommendation for another follow-up visit are most likely. Patients, then, receive further confirmation that they are, indeed, still sick.

Sickness may be further confirmed by the reliance of a bureaucratic structure on written records; in this case, then, the patient's diagnosis and prognosis (i.e., his label) recorded on paper may circulate through many hands and may become the sole basis for a treatment person's message to him. The label is the person. Finally, bureaucratic hospital organizations imply highly integrated and available referral systems; it is simple to move patients from one agency to another. Consequently, the option of discharging the patient, in other words, giving the patient confirmation that he is well, is only one of several choices the agent can make.

Thus, in a highly integrated and highly available treatment system such as our Western hospitals, two qualities seem to press sick people to remain in the sick role over a relatively long period of time. First, the

4. Our discussion of findings from Brown's study refers only to first-admission schizophrenic patients in order to make the clearest comparison with the Mauritius data.

patient's power relative to the organization is usually weak. Only those patients with high social status (Myers and Bean 1968), with considerable knowledge of the system, or with strong role alternatives (Dinitz, et al. 1961) may be able to resist the organization's messages. Second, treatment agents' messages most often confirm sickness because lack of both time and information and need for patients to justify their existence call for conservative decisions. As labeling theory suggests, messages about sickness lead the sick person, especially the less powerful sick person, to model his behavior according to the treatment system's expectations.

The effects of such bureaucratic structures upon the messages given to psychiatric patients are not limited to the West. In peasant societies where the services of Western medicine have been modeled on treatment systems in Europe or America, similar, but probably weaker, labeling effects may occur. For example, in Ceylon, Western hospitals are based on the British system; they are government sponsored, serve geographical catchment areas, and provide referral systems for specialized treatment. It is quite clear from some of the psychiatric patients followed there that family and patient control over treatment is diminished when the patient comes in contact with the Western system. Patients are sometimes transferred from one hospital to another without the family's knowledge, treatments may be given without clear explanation either to patient or family, follow-up visits are arranged without choice or discussion. The bureaucratic structure, even in the context of a peasant society, thus may generate the kind of control and thus the kind of messages the patient receives that can make shedding of the sick role more difficult.

These effects are probably even weaker in the Mauritius treatment system where the Western hospital had at the time of Murphy and Raman's study (1971) no after-care clinic, no home visits by hospital staff, and no delegation of treatment or care to a village authority. The fact that the patient, once discharged from the hospital, makes a clean break with the treatment system provides him considerable opportunity to avoid messages of sickness. This fact may, then, partially account for the better outcome of mentally ill patients treated in Mauritius.

In contrast, an examination of the system of indigenous or native treatments in a peasant society such as Ceylon shows how simple it may be for a mentally ill person to avoid receiving further confirmation of his illness from treatment agents. Native treatment people—exorcists, priests, astrologers, Ayurvedic physicians—are not part of bureaucratic organizations. Each is a private practitioner. There are no

formal links between treatment people and thus no formal referral systems. Further, there is no system of records, in fact no papers at all, that carry information about a patient from one treatment person to another. Thus, relative to treatment agents the family and patient maintain a powerful position. Specifically, they are in control of the kinds of messages that they receive about the patient's illness. For example, an exorcist must satisfy the family (i.e., give appropriate messages) since his fee may be dependent upon it. An astrologer may recommend a certain treatment person, yet the family is free to select another, or none at all. Of course, there are informal systems of relationships that may exercise certain control over what the family does (and therefore what kinds of illness-confirming messages the patient receives) but it is obviously much easier for the patient to change treatments or to stop treatments entirely than it is in the West.

Further, treatment agents are not pressed toward conservative actions since few native treatment people rely solely on this occupation for income or status; most are farmers or laborers as well. Thus, in Ceylon, where native treatment agents are not professionalized as they are in industrialized societies, their power relative to the patient is less and the patient retains greater control over his own patient career. His goal—to return to "normal"—is thus more easily and quickly reached because he receives fewer and less insistent messages confirming sickness.

Discussion

We began with this question: how can we explain cultural differences in the prognosis of severe mental disorders? We reviewed data showing that first-admission schizophrenic patients treated in the peasant society of Mauritius are much more likely to recover quickly, to return to their jobs or families, and to have no further symptoms than are their counterparts in England. This pattern seems to be true of many peasant or traditional societies. Thus, it appears that the patient's care varies with the culture.

As an alternative to the social causation and tolerance of deviation explanations of these findings, we have proposed a social response model, represented by a sociological labeling theory. In the latter theory, the duration and severity of a patient's illness are explained by the response the society makes to a sick person once

his symptoms appear. Any, or many, causal factors—genetic, biochemical, familial—can cause the original symptoms, but it is the society's response that sustains the illness.

Social response theorists have specified in some detail the sociological processes that may serve to sustain illness in one society and discourage it in another. Thus, the theory goes beyond a simple assertion that cultures expect different things of sick people and those expectations are often fulfilled. Instead, the theory focuses on social processes, on how these societal expectations are brought into play. It alerts us to the importance of beliefs about the cause and duration of mental illness and beliefs about the kinds of behavior deemed proper for a mentally ill person. It suggests that these beliefs may determine the expectations that family and treatment agents have for the patients and thus become an important component of their messages to him and the rewards they give for his playing the sick role properly. It specifies the conditions under which his sickness will be attended to or ignored; the frequency and threat of his symptoms and the extent to which his sickness is visible or impinges on others are important conditions. Finally, it provides a way of conceptualizing the extent to which the sick person can resist the society's messages; when a patient has power, relative to family members, treatment agents, and treatment systems he may resist the society's norms for the mentally ill person. Social response theory, therefore, provides a set of concepts and hypotheses that are not tied to any specific culture or cultures, but that serve as a framework for investigating the ways that any society molds mental illness to its liking.

There are certain problems, however, in testing the effects of social responses cross-culturally. When we described the way in which social response theory helps to explain the differences in the career of mentally ill patients across cultures we assumed that the treated incidence of psychosis in a particular society represented primary deviance rates, determined by nonsocial factors. It was implied that social responses to the illness have their effect only after the sick person has been officially recognized as sick. Although this is the easiest assumption to make since most epidemiological data are based on treated incidence rates, it is of course a simplification of the issue. Social responses to a sick person begin to mold his sick-role taking long before he appears as a treated case in the hospital register; incidence rates themselves are the result of social negotiations between patient, family, and society, in

which some prospective patients are shunted off the track, labeled as criminals, eccentrics, or even normal.

If social labeling begins early in the patient's career, thus contributing to the treated incidence rates, and if, as in Mauritius there is less labeling, less stigma, less confirmation of illness, why are the treated incidence rates the same there as in Great Britain? Should not these rates be lower, since mental illnesses are not serious deviations? Would not more people with symptoms be treated at home, ignored and never be seen in the hospital? This question is one that cannot be answered until we investigate the negotiation process between patient and family that occurs prior to treatment. Perhaps we would find that the initial social processes that lead to hospitalization in Mauritius and Great Britain are the same (leading to similar treated incidence rates) but that processes after discharge differ (leading to different outcomes).

How do we investigate these initial labeling processes across different cultures? To obtain a complete description of the entire social response process we should begin with the sick person very early in his career, at the point that someone, either himself or others, recognizes that something is wrong. In other words, we should begin with true incidence rates in the community. This, however, creates a problem if we are cultural relativists and assume that each society makes its own definiton of illness. If we are to measure the effect of social responses to mental illness, and to compare these effects across cultures then we must begin with standard definitions of illness that are independent of any particular social group. If we find, then, that each society processes these syndromes differently and patients have careers of different durations, we can fairly attribute the patient career differences to cultural differences in response. This means, then, beginning with nonrelative definitions of illness as Murphy and Leighton (1965) attempted to do, and assuming, with the medical model of illness, that there are syndromes that exist unrelated to a particular society's definitions of illness.

An alternate approach, more compatible with the sociological model, recognizes that each society may create its own definitions of illness, some of which match those in other societies (without assuming that the matching results from basic biological qualities of the illness or social factors). Beiser et al. (1973) has taken the first step in this latter comparative method by showing that the Senegalese illness called O'Dof is very similar to what Western psychiatrists would call schizophrenia. It would then be possible to follow

the careers of these particular sick people in the two societies and to attribute different patient careers to variable social responses to the same illness.

We have implied in our discussion of the theory and its applications that peasant or traditional societies discourage prolonged and serious mental disorders and modern or industrialized societies encourage chronicity or episodic recurrence of illness. Data suggest that this may be true of Mauritius, Ceylon and England and the United States. However, if we think twice about the important function that beliefs have in the theoretical system we might expect to find some traditional systems where chronicity is supported by the belief system and thus illnesses are of long, rather than brief, duration. Murphy (1972) reports such findings in data on long-term hospitalization and chronicity in traditional and modern French-Canadian communities in Quebec. Here, it is the traditional French-Catholic community that produces mental illnesses with long durations and impaired social performance; the modern French-Catholic community, on the other hand, is more likely to turn out patients who can return to normal roles with episodes of illness. (Modern Protestant communities showed a mixture of the two outcomes.) Thus, the Mauritius–Great Britain differences are apparent, but in reverse.

We should thus be alerted to the dangers of using such global concepts as traditional society, peasant system, modern society, industrial stage of development and attempting to link these to predictions about incidence and prognosis of mental illnesses. [See M. Singer (1972) for a critique of these categories and the assumptions that underlie them and for an analysis of one society, India, that has both traditional and modern elements, interwoven into a unique whole.] Instead, it appears from Murphy's findings and others we have presented here that we may be able to predict the duration and quality of the mentally ill person's career more accurately by looking in detail at each society's beliefs and expectations about mental illness and at the intervening social processes through which these expectations are acted out. Later, we might find that social expectations are, indeed, related to a cultural state, an economic system, religious values, or a stage in industrialization. Attempting to test such global hypotheses without first examining the internal processes that sustain the sick role seems to be both inefficient and unproductive.

While we have been concerned with the utility of the social response model for understanding cross-cultural differences in the psychiatric patient's career, the model has obvious implications for

the practice of psychiatry as well. Stated in its most unadorned form, the theory says that even though doctors, nurses, and family members are motivated to help a patient return to normal as quickly as possible, the social responses of these and other people in the society may actually function to prolong the patient's sickness. This process seems to be most apparent in Western societies where the most modern theories of psychiatry are held and where the most comprehensive hospital and clinic systems have been developed to treat the mentally ill.

Since our treatment systems and the medical professionals within them are implicated, by the theory, in the maintenance of the sick role, does this imply that the solution is to burn down the hospitals, fire the doctors, and let the patients return to the "old" ways—to rely on families, priests, and patent medicines? This solution ignores the fact that psychiatric treatment is beneficial, it does relieve symptoms, and it may cure. Instead, following the notion of labeling theory that the relative power of the patient and treatment system is crucial to the maintenance of the sick role, perhaps patient and family control over his career can be increased without concomitant loss of beneficial therapy, by increasing the participation of the wider community in the operation of clinics and hospitals; by involving more nonprofessionals in patient care; by breaking up monolithic treatment systems into small, unrelated units; or by reducing the extent to which records of patients, on paper or computer tape, circulate through the system. Implied in these organizational changes is the introduction of alternate definitions of illness; the tendency of Western psychiatry to enlarge the types of deviance that it treats (taking the alcoholics from the jails, for example), to feel responsible for prevention of mental illness in the community, and to be concerned with treating the whole life experience of its patients, is countered by alternate community beliefs, for example, that mental illness need not impair the whole person permanently, or even temporarily. Broadening the base of control over treatment systems allows varied and sometimes competing beliefs about mental illness to be represented, and may give patients more power to choose between alternate messages about sickness.

This approach has implications, also, for the introduction of psychiatric treatment systems in underdeveloped, peasant, or primitive communities. It suggests that one should think carefully before establishing a system of highly organized, extensively linked treatment structures; an overburdened hospital ward with limited bed space and no referral options may encourage short-term illnesses.

It suggests, too, the importance of retaining and using indigenous treatments, especially if they call for minimal change in the sick person's role and quick return to normality.

To return to our major concern for researchers interested in explaining why certain societies produce psychiatric illnesses that only briefly disrupt the person's normal life, an examination of the society's expectations for such patients and the ways in which sick people are "processed" is of crucial significance. We feel it strategically important to carry out carefully controlled studies focused solely (through control of other variables) on the social responses to a sick person in order to measure the extent to which these factors can account for long-term social and clinical disability. In the long run, of course, we would not expect that social responses will explain all of the variance in cross-cultural recovery rates. It is obvious that genetic and nutritional factors, treatment availability, and qualities of social life, for example, will have a place in the explanation of outcome. However, social expectations are powerful forces and we should not be surprised to find the significant and perhaps primary part they have in molding the psychiatric patient's career.

Annotated Additional Readings

a) Wittkower, E. D. 1969. Perspectives of transcultural psychiatry. *International Journal of Psychiatry* 8:811–824.
An overview of the field prepared by one of the pioneering and most productive workers in the field. Definitions are offered for main terms and concepts such as culture and mental illness. The author also presents a synthesis of the principal issues that have been studied by transcultural researchers and provides an informative list of tentative conclusions obtained from the literature.

b) Dohrenwend, B. P., and B. S. Dohrenwend. 1974. Social and cultural influences on psychopathology. *Annual Review of Psychology* 25:417–452.
An authoritative overview of the role that culture plays in the prevalence and distribution of mental disorders. After pointing toward the methodological limitations in the field, the authors discuss important aspects of the relationship between culture and psychopathology, attempting to answer in a balanced way such questions as: Are types of psychopathology different in different cultures? Is there more psychopathology today than in the past? Are rates of psychopathology higher in urban than in rural areas?

The authors point out the need for increasing methodological sophistication and suggest the usefulness of moving research in this field from cross-sectional surveys to quasi-experimental studies that exploit contrasts provided by social processes in order to test specific alternative hypotheses.

c) Draguns, J. G. 1973. Comparisons of psychopathology across cultures: Issues, findings, directions. *Journal of Cross-Cultural Psychology* 4:9-47.
A good review of some of the main issues confronting the study of culture and psychopathology. First, sources of differential findings are examined in terms of subject, observer, setting, community, and instruments factors. Then, cross-cultural findings on the incidence, manifestations, patterning, and outcome of mental disorders are examined, suggesting a considerable degree of cultural plasticity along with certain pancultural trends in these parameters. Finally, a reference is made to the relationship between deviant behavior and the characteristics of the normal population in the particular sociocultural setting where such deviant behavior takes place, making a point for the so-called "caricature theory" of psychopathology.

d) Dunham, H. W. 1976. Society, culture and mental disorder. *Archives of General Psychiatry* 33:147-156.
The author, who had neatly teased out with Faris several explanations for the differential urban distribution of schizophrenic patients (Faris and Dunham, 1939), provides a review of mechanisms by which social and cultural factors

may play a role in the development of mental illness. Dunham complements his review with 15 tentative conclusions mainly related to schizophrenia and the psychoses.

e) Fabrega, H. 1975a. The need for an ethnomedical science. *Science* 189:969-975.
This is an incisive analysis of the nature and historical roots of the biomedical model, its strengths and limitations, and a justification of the need for a new medical model that takes into account how different cultures think about disease and organize themselves toward treatment.

The paper describes a strategy to develop an ethnomedical paradigm which encompasses concerns relevant to both social and biological sciences. The relation which exists between disease, social behavior, and human adaptation, the primary subject matter of ethnomedicine, is examined at the light of man's unique capacities for symbolization and culture.

This paper offers an excellent preparation and complement, from an epistemological and anthropological perspective, for Engel's article (2).

f) Eisenberg, L. 1977. Psychiatry and society: A sociobiologic synthesis. *The New England Journal of Medicine* 296:903-910.
Emphasizing the concerns of the clinician, the author addresses the questions raised by certain uses of labeling theory in the sense that psychiatric diagnoses are mainly labels to legitimate social segregation of people whose behavior is disagreeable and unwanted.

The author calls attention to the interaction of social with psychological and biological factors affecting prevalence, causes, and outcome of human disease. This paper is helpful to put Waxler's article (3) in a clearer and more comprehensive perspective.

g) Murphy, J. M. 1976. Psychiatric labeling in cross-cultural perspective. *Science* 191:1019-1028.
A comprehensive review of the perception of abnormal behavior in diverse cultures taking advantage of the author's field experience with the Eskimos of northwest Alaska and the Yorubas of tropical Nigeria. Particularly notable is the documentation offered on the universal detection of several psychiatric disorders.

The author strongly argues against using labeling theory to represent an explanation of the development of mental disorders, although this is neither the only nor the most appropriate interpretation of the theory as Waxler explains. This theoretical paper complements Eisenberg's clinical analysis of labeling theory (f, above).

h) Townsend, J. M. 1975. Cultural conceptions and mental illness: A controlled comparison of Germany and America. *Journal of Nervous and Mental Disease* 160:409-421.
A comparison of responses of samples of 100 psychiatric inpatients in Frankfurt and in California to administered questionnaires exploring their concepts about curability of mental illness, characterization of a mentally ill person, and purposes of psychiatric hospitalization as well as their self-

perceptions. The author found that exaggerated stereotypes of the mentally ill were not endorsed by the majority of patients in either sample. On the other hand, the German patients (and also hospital staff) espoused a more fixed and endogenous and less "free-will" conceptualization of mental illness than their counterparts in the United States, and these differences appeared reflected in differential perceptions about proper behavior in the hospital. The author discusses these and related findings in regard to various sociological theories of mental illness. With this perspective, this paper complements the statements by Waxler (article 3) and Murphy (g, above) on labeling theory.

i) Oetting, E. R. and W. W. Stein. 1966. Popular medical beliefs and attitudes toward mental illness in Peru. *Human Organization* 25:308-311.
An exploration of attitudes and beliefs about mental illness among professional and subprofessional staff of four psychiatric hospitals in Lima, Peru. The investigators found that those scoring highest on the "humanistic" end of an "ideology scale" consisted almost entirely of psychiatrists, general physicians, and nurses and tended to disregard "bad food" and masturbation as main causes of mental illness. On the other hand, those scoring at the "custodial" end of the scale consisted almost entirely of hospital attendants and most of them agreed that "bad food" and masturbation were principal causes of mental disorder. The latter group appeared to be in line with popular or folk beliefs in Peru. The paper also discusses the influence of these contrasting conceptualizations on the staff's behavior and interaction with patients.

j) Gaviria, M. and R. M. Wintrob. 1976. Supernatural influence in psychopathology: Puerto Rican folk beliefs about mental illness. *Canadian Psychiatric Association Journal* 21:361-369.
This paper reports on an investigation of both natural and supernatural etiological factors of psychopathology as conceived by Puerto Ricans living in the Northeast of the United States. Furthermore, it explores the relationship between such conceptualizations and the relative use of standard treatment services and folk healers, and proposes some practical recommendations.

An interesting finding is that the individuals contacted identified two main forms of being mentally ill: the *loco* (crazy) and the *nervous* (characterized by depressive and anxiety symptoms). This information from a "cultural" study may be quite useful to enlighten the current controversy in the mainstream of U.S. psychiatry about the value of "psychosis" and "neurosis" as major classificatory principles for mental disorders.