

# Race Renounced, Culture Arraigned: The Case of the So-Called Culture-Bound Psychoses

Barbara Lovric

Scanning the literature on culture and disease in developing regions of the world, one is struck by a peculiar paralogism. Ethnopsychiatric studies and psychodynamic anthropological formulations suggest that the ills of the impoverished are largely psychogenic, psychosomatic and culture-induced. A high frequency of mental disease, once linked to racial infantile mentality, is now imputed to a 'cultural personality' generally predisposed to a poor tolerance of anxiety, to somatising social distress and conflict, or to acting out unresolved tension through aggressive panic or hysterical deviance (cf. Stoller 1969; Wittkower and Termanson 1969; Obeyesekere 1970, 1977; Leighton 1982; Kleinman 1980). The high incidence of diseases manifesting mental symptoms among populations of Southeast Asia in general and the poor in particular is indisputable. But is a significant proportion of this morbidity actually due to a kind of cultural deficit? What of the ecological, biochemical and genetic factors involved in the dynamics of mental disorder?

Unfamiliar magico-medical rituals, assumptions concerning the supernatural and a set of bizarre symptoms and signs among the local populations of colonised Southeast Asia attracted the attention and imagination of Westerners who observed them or read about them. Local names (e.g. *amok* and *latab*) were retained in many accounts and experts in the field, such as Yap (1967:173), considered it essential to integrate these 'exotic syndromes' into recognised (Western) classification and standard nomenclature. When clinical manifestations were not directly equatable with anything described in Western medical experience, the syndromes were labelled 'atypical culture-bound variants of reactive syndromes' (Yap 1967:175). Deviations from Western definitions of abnormality were aberrations.

Paradoxically, culturally defined witches and demons and related fears and anxieties, together with possession affliction syndromes and voluntary

trance states, are all accommodated within this classification of culture-bound psychogenic psychoses (cf. Leff 1981:16). But in indigenous magico-medical experience and classification these phenomena may be attributed to three clearly differentiated categories. In the Balinese context, witch fear and anxiety (which pertain to illnesses of which they are imputed agents) is normal and rational. Involuntary affliction possession (such as *babainan*) is disease. Voluntary trance states are not. In terms of aesthetics and function, volitional, controlled possession states are unlike non-volitional possession affliction such as *babainan* which is a manifestation of pathology. The fact that voluntary possession states served the interests of the community was no argument against their abnormality, or so Yap ruled (1967:175).

This ascription of abnormality to actions proceeding from indigenous epistemological assumptions about supernaturally-endowed agents in the spread of disease and human mystical participation with the supernatural, together with the denial of a possible organic basis to unfamiliar forms of morbidity among different (Asian and non-Judeo-Christian) populations, promoted Western attempts to diagnose whole cultures psychiatrically, if not psychotically. Postulating a category of culture-bound syndromes meant that indigenous medical ideologies, repressive social structures and culture predilections generated their own forms of morbidity. But such studies have not led to a satisfactory understanding of all the problems and patterns of morbidity in Asian populations. Instead, what they highlight is a problem, particularly in psychoanalytically-oriented paradigms constructed to explain these conditions.

Although not addressing the more complex issue of transcultural psychiatric research, Ellard offered the following warning which is relevant to the present issue:

One of the deadly charms of psychiatry is that being a subject without boundaries it encourages the contemplation of large and complicated questions. This in turn provides an opportunity of reaching magnificent, all embracing answers, so reducing human complexity to such pellucid insights as to cause all to marvel. The unfortunate result is that not only does speculation proliferate while the answers remain elusive, but also after a time the speculations become mistaken for the answers, and we arrive at exquisitely fashioned shadows with no substance in them (1985:17).

It is possible that some forms of culture-bound syndromes are atypical variations of Western forms of psychogenic psychoses. It is equally possible that they are morbid conditions without any clear Western medical counterparts. To confine the labelling of them to Western psychiatric nosology is perhaps to miss their actual as well as their putative significance.

The uneasy interface in Western medical discourse between neurology and psychiatry (specialties addressing organically based and functionally based mental disturbance respectively) is not apparent in the study of syndromes such as *babainan* among Asian populations. Only one aspect is represented and it is in no way neurologically or even biologically inclined. These studies rely on the conceptual frameworks, axioms and implications familiar to Western social psychiatry and psychoanalytical anthropology (cf. Surya 1969). Psychiatry's incursions into sociology, and the reverse, are reflected in these formulations. Mental disease has been a particularly fertile source of debate and disagreement and, allied to the notions of race and culture, it becomes an even greater polemic, one to which I shall return in the final section of this paper.

I turn now to discuss Balinese *babainan*, a culture-bound functional disorder, according to the Western formulations mentioned above, but labelled aetiologically as possession affliction and defined as organic illness in indigenous medical theory. When I refer to Javanese *latab*, later in this paper, I refer back to the lesser known (outside Bali) *babainan* in order to question the validity of the use Westerners have made of, first, race and then culture as significant contributory factors in the genesis of disorders which essentially belong to the category of phenomena-not-yet-understood.

#### (i) *Babainan*; Case Studies

In Balinese cognisance and medical discourse, to be afflicted by a virulent, live magical spell called *babai* through the intermediary of a witch (*leyak*) is to suffer an organic illness named *babainan*. Depending on the peculiar nature of the 'invading organism' (*babai*) and the tissues or organ wherein it settles, symptoms and signs ranging from mild physical discomfort to severe mental distress ensue. The disease may present as an acute episode, quickly resolved or, more frequently, as a chronic illness with acute episodes. In terms of diagnoses by *balian* (healers) - and less than 2 percent of the population have their illnesses diagnosed by Western-style doctors (*Bali Post* 22 October 1976) - it is among the most frequently occurring diseases. It is also one of the most feared and dreaded. The disorder is not of recent origin. Local medical texts (*usada*) describe the aetiology, pathogenesis, clinical manifestations and treatment for *babainan*. Case examples from fieldwork where I observed *balian* at work convey some notion of the form and context of *babai* affliction:

1. 20/ 11/ 81 The illness from which a man in his middle fifties was suffering was diagnosed as *babainan*. His main symptoms were weakness, palpitations, aching pains in the limbs and difficult micturition. He had already been to a local health clinic but, allegedly, the cause of his discomfort had not been determined nor had a diagnosis been made. He had con-

sulted the healer several times previously, and the severity of his symptoms tended to fluctuate. This time the *balian* prescribed medical therapy in the form of mantra, ablution with purified water, the ingestion of an incinerated magical drawing and the inhalation of burning incense among other things. Thereafter the *balian* took a black peppercorn and pressed it into each of the man's finger tips in turn. He was searching for evidence of the area of activity of the *babai*. Wherever the procedure induced no pain, the *babai* was deemed to be no longer active in that portion of the body. The *balian* then took a piece of black wood, held it over burning incense, breathed upon it and placed it between the man's third and fourth toes, pressing the toes inward against the piece of wood. The man writhed in apparent pain and cried out. This was, it seemed, the point of entry and the focus of activity of the virulent *babai*. The *balian* continued applying what did not seem to me to be very strong pressure to the toes for a few seconds longer and the man continued to moan and cry out begging him to cease.

Finding the exact location of the *babai* and compelling it to acknowledge its presence, which it had done through the cries of the man, was not tantamount to a resolution of the sickness. It was only the beginning. The man would return to the *balian* several times more to build up his own strength and resistance. Ideally, in time, the *babai* would concede defeat and announce its intention of relinquishing its hold on the body. I was told that this was a very severe case of *babainan*: the *babai* had been created on Lombok and at times the man suffered nervous symptoms such as moodiness and disorientation when the *babai* moved from the lower part of his body up to his head.

2. 24/ 1/ 82 A woman in her early thirties with three children had been ill on and off for seven years and had been to the hospital 'for injections'. Her illness was diagnosed by the *balian* as *babainan*. She complained of weakness in her legs and severe pain behind her eyes and sometimes in her head. Her husband explained that she was often listless and without energy. The treatment procedure was essentially the same as that already described. The *balian* also applied a concoction, consisting of oil from a species of freshwater fish and spices, to the woman's eyes. Pain behind the eyes was the symptom which apparently bothered her most. She cried out during this treatment and then kept spitting for some time after. I was told that if there had not been a *babai* there she would not have experienced such violent reaction. The pepper and wood application to the hands and feet had not elicited any pain reaction. The *babai* had already moved from those locations.

3. 21/ 10/ 81 An eighteen year old male was diagnosed as suffering from *babainan desti*. This name referred to the mechanism (*desti*) whereby he

contracted the illness. The affliction was also named *babai bongol* because at one stage deafness (*bongol*) represented the dominant symptom. At another phase of the illness, that of active delirium, he had run away aimlessly. The illness had then been renamed to indicate a particular manifestation of mental disturbance. At this stage the boy was in an abnormally agitated and frightened state and looked dazed and disoriented. I learned later that, in what had seemed to me to be no more than confused muttering, the *babai* had acknowledged and named a local *balian* as its 'owner'. The *babai* requested that a ritual be conducted at the graveyard on its behalf. The request was agreed to and fulfilled. The *babai* 'disappeared' and in time the boy became symptom-free.

4. 5/ 2/ 82 A twenty-three year old woman related the events surrounding her illness with a kind of detachment one might expect of a disinterested spectator. She had been feeling quite well and then one night shortly after going to bed she suddenly started raving and hallucinating. She was admitted to hospital under a *doktor syaraf* (nerve doctor) and 'given injections'. The visual and auditory hallucinations and the raving ceased. She was discharged from hospital but the symptoms recurred. She was then taken to a *balian* and given the standard treatment. Apart from the disturbance of consciousness, she also remembered that when she was in the acute stage of the illness her body seemed to be grossly enlarged and at times she was unable to walk.

The ravings of the *babainan* sufferer are not considered to be their own but those of the living *babai* spirit. The objective of sometimes violent questioning and treatment is to induce the *babai* to name its purchaser or, less frequently, its owner-creator. No formal redress is sought by the *balian* and no moral judgement is pronounced. The sociological significance of *babainan*, I suggest, lies in its imputed aetiology and treatment, namely, in the complex of suspicions and manipulations inherent in illness episodes and the powers of the creators of *babai* on the other. I forego such an analysis here in favour of a more cognitive study and a search for a meaning of the phenomenon itself which is consistent with the medical data that local texts yield.

#### (ii) *The Creation and Path of the Pathogen (Babai Spell)*

The term *babai* is cognate with *bayi* meaning 'foetus'. It denotes a magical spell, the most potent form of which is concocted around an aborted foetus, a stillborn infant or a placenta. A *babai* is not ambiguous; its virulence is unequivocal. Its reason-for-being is to induce disease in its human host. In some respects *babai* is not unlike the Malay concept of *fbadi* (cf. Endicott 1970:69-83) which, according to Endicott, represents the loss of control, the crucial boundary between life and death. Its exceedingly malignant, marginal and uncontrollable nature renders it an object of fear.

The only ambivalence associated with *badi* (and the same applies to *babai*) is that it does not clearly belong within either the category of supernaturals or humans.

However, *babai* also share characteristics with the Malay *pelesit* which is a familiar spirit acquired through the magical manipulations over a corpse of an infant who was the first-born of first-born parents. A common form of spirit affliction during pregnancy, the *pelesit* is imputed to enter the body through the feet causing the victim to scream with pain and lose consciousness. Like the *babai*, it is exorcised through mantra and demands that it should reveal, through the mouth of its host, the identity of its 'parents' (owners). If this fails to elicit a confession, the Malay *bomor* (shaman) applies pressure to the fingers and the toes of the afflicted and carries out an interrogation until the *pelesit* finally confesses and agrees to leave (Gimlette 1923:42-3; Endicott 1970:57).

Marginality and ambiguity are characteristics of things magically powerful and dangerous in Balinese thought. Foetal material, post-partum and menstrual blood, matters which pertain to life and procreation, are all imputed to represent the most potent sources of power for the creation of *babai*. The products of miscarriages procured for the purposes of creating *babai* are placed in containers and buried in graveyards, spiritually nurtured and given offerings as well as life-cycle rites. They are also finally taken to temples associated with the powers of death where, through the intercession of the Goddess of Death, Bhatari Durga, they receive their power and privilege and become her representatives. The abundance of information concerning the actual procuring and raising of a *babai* testifies to the extent to which the phenomenology of the symptom complex, which the Balinese term *babainan*, has influenced an elaboration of its aetiology (cf. Weck 1937:205-12).

Though treatment aims ultimately to rid the body of the *babai*, immediate expulsion is not considered a possibility. Medicinal therapy, offerings and mantra to deities of fire, such as Agni and Brahma, anticipate a gradual weakening of the *babai*'s hold within the body of the host. An extinction or even permanent extrusion of the *babai* is not presumed a likely resolution to *babainan* affliction. Mantra prescribed to prevent, contain and reverse *babai* affliction are numerous. Requisite ingredients are copious and expensive, consisting of animal, vegetable and mineral origins, either buried, formed into a potion or applied to the afflicted.

Allusions in the treatments to a flaming, burning and fiery resolution of *babai* intrusion are prominent. In the form of therapy called *tutuban* the *babai* is expected to react to the heat and burning caused by the concoction applied to the eyes of the afflicted. Mantra are frequently addressed to

Brahma whose colour is red and whose quality is fire (cf. HKS2183:20a). Magical drawings used in association with mantra to expel or incinerate *babai* display a fairly distinctive but limited range of motifs. Mystical syllables and geometric forms based upon the emblems of the deities of the nine directions feature prominently. Mystical syllables are usually found in association with a flaming human head. Composite human-animal representations of demonic appearance are used in conjunction with mantra invoking the powers of high deities so that the virulence of the *babai* is extinguished (K422:10,5). To prevent the access of *babai* into a houseyard, a piece of copper one hand-span in length and three fingers in width, on to which a magical drawing of the Yama-Raja figure is inscribed, should be buried in the middle of the yard. The Yama-Raja figure, a grossly enlarged part-animal part-human form, perhaps representative of the visual hallucinations and distorted perceptions of *babainan* affliction (see case study 4), is a conspicuous part of the imagery of physical and mental pathology. Perhaps the most distinctive magical drawing associated specifically with *babainan* is that named *bawange*. It should be inscribed upon an onion and buried below the sleeping platform of one possessed of *babai* (cf. HKS3124:4b). Some similarity to a developing embryo (the position and unequal development of limbs notwithstanding) or a malformed one might be intended.

The presumed existence of people capable of acquiring the knowledge and means of creating *babai*, and thereby insidious and debilitating forms of disease among individuals, is an obvious source of anxiety among the population. There are descriptions of *babai* created on the nearby island of Lombok through the sexual union of male and female witches. Such *babai* might have the form of an infant with a grossly enlarged head, exhibit facial and cranial features of a cat or a monkey and produce a cry reminiscent of sounds normally produced by ducks. Animal imagery is a constant element in Balinese medical phenomena.

What also invites thought and begs elucidation is the prominence of human stillbirth, miscarriage and missed-conceptions (menstrual blood) in indigenous aetiologic conceptions. The mystical power of the human embryo, the potential of menstrual blood and the anomalous nature and magical potency of a fresh human corpse in general, and of a stillborn in particular, are discernible themes of Balinese magico-medical theory and practices.

Interestingly, supernaturals who participate with humanity in voluntary trance possession are commonly 'child-like' in manner and name. Infants or 'small humans' also feature prominently in graphic representations of mystical agents involved in the pathogenic process. The key to the symbolism in the *bawange* drawing may lie in a specific form of foetal malformation perceived to be caused by amnion rupture during gestation. Foetal

digits or members (such as a foot or an arm) *in utero* can become entwined by fibrous strands resulting in constriction bands and leading to partial or complete amputations. The subject of amniogenic foetal malformations is one of the oldest medical mysteries (Torpin 1968:4).

Possibly, the peculiar status of the unborn foetus, neither ordinary human nor supernatural, is the basis of this particular archetype and analogical signification. The semiotics of *babai* as a supernatural pathological agent might perhaps then be understood through the notion of projection and dialectical reversal. That is, *babai* project a reality - high infant mortality rate, miscarriage, foetal malformations, stillbirths and infertility - superimposed upon or transcoded within another, namely, a ubiquitous and analogous form of morbidity which commonly manifests only after puberty. Elsewhere (Lovric 1987b) I argue that the symbolism in other prominent cultural representations also encode morbid realities.

Local understanding and theory of *babainan* is based upon intimate experience and keen observation. Forasmuch as the disease is attributed at one level of causation to *babai* (an 'irrational' proposition in Western scientific thought), this is no reason to discount local classifications and symptomatology as being devoid of clinical significance, or to relegate the syndrome wholly to the psychosocial arena.

### (iii) *The Medical Semiology of an 'Exotic' Syndrome*

A manuscript transliteration (HKS2183) of a Balinese medical text entitled *Tingkah ing Ngubah Babai*, 'Procedure for the Raising of Babai' tells us that:

...there are *babai* without form, without abodes, emerging through desire, through thought, through the mind, the breath and speech...

Knowledge of the unmanifest potent endowment of *babai* which produce disease includes the following;

I Mjajapati becomes *pamali* [a disease spell] causing a stabbing pain, returns to its place of origin and becomes the *babai* named I Truna Bagus causing pain and manifesting as an illness named *lara bub* ['swelling affliction'].

I Anggapati becomes *dengen* [a disease spell] and settles under the chest causing migratory severe stabbing pain. It eventually settles in the abdomen and then returns to its abode in the soil and an illness named *tiwang* [convulsive seizures] appears.

I Amad is able to create a disease in which symptoms persist for many years.

If the afflicted person cries and screams, I Mlata has created the disease.

If the afflicted person remains silent, withdrawn, quiet and mute and is oedemic, I Bongol has made the disease.

If the afflicted person compulsively utters incantations and prays using meaningless phrases, Sang Ermas, the *ratu* of all *babai* is responsible for the disease.

I Jinjin creates a disease which manifests with confusion.

I Buk creates a disease which manifests with tingling sensations and pain in all the joints.

I Bodo causes generalised pain.

I Ariman is able to cause death.

When a wide range of symptoms and signs are displayed by the afflicted, the illness is named I Mas-Rejek-Gumi who has thirty dynamic manifestations. Each pursues a different pathway, settles in a different location in the body and causes changing symptoms. Tests state that there are thirty-three forms of *babai* and a similar number of locations in the body where they are apt to settle. The signal cue about the differences in kind pertains to the form in which the disease presents and the location of distress in the body.

*Balian* also refer to other *babai* named according to the symptoms they cause. *Babai Dewa* causes its host to speak in a high-pitched voice and to pray all the time, that is act as though possessed by a deity (when one is not). *Babai Amuk* causes its host to speak crudely, act defiantly, seize weapons and attack others randomly and without cause. *Babai Ganjab* causes a loss of memory and aimless roaming. *Babai Asmara* causes uncontrollable and unprovoked laughter. *Babai Negul* causes pain in the chest. The most potent *babai*, alleged to originate on Lombok, enters the body and causes gross swelling of the abdomen.

Another text on *babaman*, sundry neurological and somatic symptoms and herbal treatments, entitled Usada Sasah, lists a further group of *babainan* manifestations; confusion, hazy vision, ringing sensations in the ears, coldness (beginning in the feet and gradually enveloping the whole body), fear, terrifying visual hallucinations, epigastric and abdominal pain, uncontrollable crying and yelling followed by withdrawal and unnatural quietness.

The texts state that the illness has no one single cause as manifestations and presentation of it are varied and manifold. It may begin in the lower abdomen with sharp pain as if something is being thrust into that part of the body. The pain appears suddenly and recurs intermittently. It may move to

the centre of the abdomen, then on to the liver. When the *babai* moves to the head, the afflicted becomes dizzy, hallucinates and behaves like one insane. Such a person may become unconscious. When the neck is the location of the *babai*, it becomes swollen, stiff and sore, its vessels become rigid and swollen and the afflicted is unable to speak. Feelings of suffocation and choking may follow. If the tongue becomes the location of the *babai*, the afflicted behaves like one possessed by deities, speaking in a high-pitched sweet tone. They are weak and lethargic and stagger when walking (K422; HKS113,7; HKS2184).

The maintenance of normal body temperature (lack of fever) is a defining feature of *babainan*, according to *balian*. The major manifestations classified as belonging to the *babainan* symptom complex do not generally occur during the febrile phase of an illness. This seems to differentiate *babainan* from *tiwang* (infective neuropathies) and to place it closer to syndromes included in the *tujuj* (nutritional neuropathies) category. There is patently some overlap which has been observed and documented (cf., HKS3097). In both categories of disease there are manifestations of central nervous system disturbance and sensory and motor manifestations of peripheral neuropathy (progressive paralysis, paraesthesia, for example).

Have the Balinese fabricated this symptom syndrome and diligently recorded it in their medical manuscripts? Or have they observed a seemingly related spectrum of disorders with mental, sensory and motor symptoms and recorded them under the generic aetiologic name *babainan*? In Balinese medical theory, the syndrome is not mere psychogenic reaction.

To transpose this indigenous recording of a syndrome into Western medical parlance, *babainan* manifests with physical, sensory or mental symptoms, or all three. The most characteristic somatic features of the disease are swelling, often of the abdomen, partial facial swelling and palsy, migratory sub-cutaneous nodules often located around the neck or limbs and itchy skin lesions. Pain, weakness and partial temporary and recurrent paralysis are the major symptoms and signs. Sensations of numbness, tingling, burning and prickling are common. Pain, of a sharp, shooting or stinging quality is located most frequently in the epigastrium, lower abdomen, neck, throat, eyes, head and joints. Mental symptoms cover a wide range of perceptual and cognitive impairment and distortion of consciousness ranging from partial loss of awareness to complete confusion, stupor and temporary loss of consciousness. Tremors and partial and generalised spasms described under the generic diagnostic category of *tiwang* are generally absent from the *babainan* symptom complex. Violent motor excitement, nodding of the head, rhythmic moving of the eyes, grasping and sucking reflexes, characteristic of *tuju* and *tiwang* symptomatology, are also absent from local descriptions of *babainan*.

The multi-dimensional *babai* is the imputed initiator of a wide spectrum of pathologic conditions. *Babainan*, the symptom complex itself, enjoys remarkable notoriety but it is not a highly communicable disease. There is no mention in the texts of epidemics with associated high mortality rates, but it is endemic and a common cause of morbidity. *Balian* concede that it is one of the most difficult to treat of the theoretically curable diseases; some people afflicted with the condition recover in a few days while others remain afflicted for months, years or a life-time. *Balian* do not consider *babainan* to have a higher incidence among women, nor is it a disease of neonates and infants. It occurs only rarely among children. *Balian* handle most cases of *babainan*. Western-type doctors do not generally claim to understand the disease; the syndrome is not described as such in the Western medical textbooks. 'Scientific' interest in indigenous medical knowledge does not extend much beyond a search for possible benefits of 'unknown' (miracle) herbal remedies.

On the basis of comparative data and the trend in Western studies referred to earlier, psychodynamic theorists posit that Balinese medical ideology, concern with witches and demons and social repression have created a culture-bound reactive psychosis. In the limited range of material on the subject, *babainan* is situated in the ethnopsychiatric model of 'madness' which rejects a bio-medical paradigm for the study of psychiatric morbidity, supporting instead the Laingian psychological credo that mental disorder should not be regarded as disease but an intelligible reaction to insane sociocultural arrangements. That is, those diagnosed as suffering from psychological dysfunction are actually the 'blessed mad' with special insight: *babainan* symptoms in this model represent 'one response to a wide range of transient and ongoing stress in Balinese social life' and the condition is a means of releasing violent emotions strongly suppressed in the context of culture (Connor 1982:785).

A local non-Balinese Western-style doctor told me that she treated *babainan* 'Christian-style', with injections and Christian prayers. She suggested that the 'Balinese religion contributed to *babainan* because of belief in evil spirits'. In her estimation, *balian* cannot distinguish between neurosis, psychosis and epilepsy, but lump them all together as *babainan*. A non-Balinese Western-style psychiatrist practising on Bali (personal communication) does not consider *babainan* to be the exotic syndrome it is alleged to be but says the term covers a wider field than psychiatric disorder. Many such acute illnesses can be classified as *babainan* and he proposed that there may be two forms of *babainan*, an organically based and a functional one. This may represent a satisfactory compromise explanation for the syndrome.

Excluding for a moment the manifestations of mental derangement, the

sensory and motor symptoms of *babainan* can be considered alongside such Western clinical categories as peripheral neuropathies and parasitic disease, the aetiology of which is associated with infection and nutritional rather than socio-cultural deficiencies. In the tropics, the causes (besides beriberi and pellagra which I have identified as of the *tuju* category of disease) of peripheral neuropathy are legion although uncertain (Maegraith 1984:334). The invasion of the human body by helminths (parasitic worms) may cause symptoms ranging from skin lesions to dementia. Obscure spastic paraplegias are common in South India (Taori and Iyer 1973). Paraplegias of unknown origin, reported from parts of Africa, are believed to be nutritional in origin (Weatherall 1983:21,149-57).

The syndrome of tropical ataxic neuropathy, described in certain Asian and African communities, commonly present with various forms of paraesthesiae in the extremities. Blurring of vision, ringing sounds in the ears (tinnitus), deafness, weakness, unsteadiness of gait and colicky abdominal pain are common symptoms. The syndrome may result from dietary deficiencies, viral infections or primary genetic factors. The condition generally affects males and females equally around the fifth decade of life (Weatherall et al., 1983:21, 154). A juvenile form of motor neurone disease, where the average age of onset is 15 years, has been described in South India. The condition is characterised by weakness of the limbs, difficulty in swallowing, atrophy of the tongue and bilateral (nerve) deafness. Observable and palpable twitching of muscles in the extremities is common (Wadia 1973:21, 152). Sensory impairment of polyneuropathies usually involves the hands and lower limbs. Touching the skin can aggravate paraesthesiae. Stimuli normally not painful can cause unpleasant sensations and repeated stimulation in the same place may cause pain to spread and reach intolerable intensities. The clinical presentation therefore of some cases of *babainan* and symptomatology of *babainan* as presented in local medical writings suggest possible parallels with these kinds of physiological stress.

As mentioned, part of the *babainan* diagnostic strategy employed by *balian* involves pressing stimuli in the form of a peppercorn or a sharp piece of wood against the fingers, toes or soles of the feet. Pain arising from such stimulation indicates the presence of the pathogen (*babai*). An appropriate mantra is uttered and thus it becomes a diagnostic tool through which the *balian* traces the position of the *babai* within the body. Presuming that these practices do indicate some neuropathological disease, albeit not explained in Western terms, I suggest that a classic peculiarity of a frequent symptom has been encoded in a traditional magico-medical technique.

One might also wonder if the migratory swellings or nodules, also part of

the confirmatory symptomatology of *babainan*, indicate reactions to parasitic nematode (worm) infections. Moderately severe cases of larval hookworm disease produce visceral symptoms, marked weakness, rapid fatigue, dizziness, tinnitus, headache and palpitations. Severe infection causes intensification of the symptoms together with oedema, abdominal distention, epigastric pain, abnormal perverted taste, breathlessness, paraesthesiae, depression and syncope. Paraesthesias, consisting of exaggerated sensitivity to touch, are a clinical expression of other nematode infections.

Human infestation with the encysted larvae of the pork tapeworm (*taenia solium*) is characterised by variable and unpredictable symptoms of motor and sensory disorder and painless subcutaneous nodules due to the localisation of calcified cysts. Psychiatric symptoms may develop as an isolated syndrome, varying widely from simple hallucinations, slow-mindedness, emotional disturbance to confusion, apathy, global amnesia and dementia. These may be transient or develop progressively. The fatality rate in untreated symptomatic cases exceeds five percent. The survival time varies from a few minutes to thirty-five years from the onset of the first symptom (Warren and Mahmoud, 1984). Filarasis, a highly prevalent form of worm infection produces in different hosts a broad range of clinical manifestations. Thus, it is suggested that a variety of disorders may be diagnosed as *babainan*. Here I have shifted into a Western medical frame of reference because I perceive no alternative means through which to investigate the problem of a not-yet-understood phenomenon and the epistemological basis of *babainan* symbolism, although I recognise another way of knowing, another epistemology and another way of encoding reality. What I have done is place the symbolism of *babainan* in a context and I have sought relational meanings.

The proposition of physiological aetiology should not be seen as contradicting the *balian* construction of *babainan*, for this itself has constituted my primary analytical data. Moreover, it is essential to think about other ways of knowing and about the cultural expressions and elaborations woven around the disease experience, and to seek to understand the logic in other classificatory systems, descriptions of symptomatology, diagnostic processes and forms of treatment. When similar motifs and symbols in various local constructions of disease are found among peoples at a similar level of technological development, who are also vulnerable to similar microbes and the effects of malnutrition and infection, some consideration may also be given to the capacity of the pathological process itself to inspire symbolism.

A related matter I wish to stress is the lack of Western understanding of tropical neurology. Exceedingly complex problems await neurological

research in tropical Asia (cf. Wadia 1973; Spillane 1974; Edington and Gilles 1976; Brown and Voge 1982) where there is a high incidence of some recognised neurological conditions and of as-yet-undescribed conditions:

The assemblage [there] of clinical material is more glaring than in a temperate environment and the diagnosis is often harder to achieve. The visitor's outstanding impressions are likely to be two-fold: the gross affliction of the stricken and the obscurity of many of their illnesses (Spillane 1974:269)

Descriptive neurology, like psychiatry, is largely based upon experience in temperate climates in technologically advanced cultures among nutritionally advantaged populations where sanitation is adequate and parasitic infections are not common. Even the limited range of colonial medical investigations and interventions on small and unrepresentative samples of colonised populations yielded awareness of obscure forms of morbidity. I suggest therefore, that syndromes such as *babaiman* may express gross manifestations of central nervous system and peripheral nervous system dysfunction which are no longer familiar to Western nosography, or perhaps have never been part of the symptomatology of nervous disorders in temperate Western regions. Those approaches based on the hypothesis that syndromes such as *babaiman* are psychosocial in origin, and therefore a product of cultural dysfunction, are perhaps a consequence of the tendency of the social sciences to avoid physiology (see Fabrega 1977:274; Freeman 1983:294).

In the section below, I use the well-studied case of another culture-bound syndrome, that of *latab*, through which to demonstrate my assertions. There is an extensive literature on *latab* (cf. Winzeler, 1984) but no indigenous data.

*(iv) The Problem of Not-Yet-Understood Ethno-medical Phenomena;  
The Comparative Case of Javanese Latab*

Unfamiliar forms of morbidity encountered by Europeans in colonised regions sometimes presented an affront to their codes of ethics and etiquette. Interest in and concern for their medical implications came much later if at all. There is no mention in the colonial medical literature of *babaiman*. Although the colonial medical discourse on culture-bound syndromes such as *latab* and *amok* was carried out largely by medically-trained observers who acknowledged the importance of infections, especially malaria, as exciting causes, they nevertheless retained the notion that some residual (evolutionary) endogenic psychical processes contributed to these diseases.

*Latab* is a specific syndrome characterised by an abnormal startle reaction,

fearfulness, loss of control, hypersuggestability and temporary dissociation. Pallor, palpitations, shaking, groping and scratching movements with the hands may also be present. A disturbance of language ability takes various forms such as meaningless utterances or lavatory babble (coprolalia), fornication babble (pornolalia), involuntary blurting of crude sexual terms, phrases or suggestions, verbal mimicry (echolalia) and bodily mimicry (echopraxia). In addition, automatic obedience can also be a confirmatory sign of the affliction. The immediate exciting causes may be auditory, visual or tactile, and symptoms may be preceded by an initial dream, sometimes of an erotic nature.

Colonial observers did not seriously consider ecological and bio-medical factors or the possibility of organic dysfunction of the nervous system in *latab* crises. Instead, they postulated the existence of innate racial psychological qualities, or that the crises related to 'untrained mentality', 'infantile-primitiveness' and such-like (van Loon 1924; Theunissen 1921; Fitzgerald 1923). As Yap notes, Scheube (1903) included *latab* along the sprue and dysentery under a chapter title of organic diseases of tropical regions and Mansell labelled it a 'pathogenic disease' peculiar to 'barbarous and semi-civilised countries' and to the 'weak-minded of the advanced ones' (Yap 1952:517-24). According to Winzeler, Clifford (1898) criticised medical interpretations of *latab* for lacking what he perceived as humanistic concern, and provided instead the explanation that the Malay character was rooted in morbid nervousness (Winzeler 1983:83-5). Travaglino (1920:38) concluded that the Javanese and kindred races were 'psychotically and morbidly emotional' and Fitzgerald noted that '*latab* is due to suggestion in an impressionable, neurotic, and weak-minded person...' (1923:155). In other words, people exhibiting probable signs of disturbance of the nervous system (including epileptiform illness and encephalitis) were all classified as lunatics. The colonisers built asylums and confidently postulated that all their health problems would soon be overcome if only the natives would learn to wear shoes and be 'more like us'.

Yap, a British-trained psychiatrist, who wrote extensively on culture-bound syndromes, saw *latab* as a form of fright neurosis, culturally determined and maintained among those hypersensitive to fright and whose defenses were limited by the level of their cultural and technological development (1952:560). He suggested that the adoption of bizarre behavioural symptoms was the only recourse available to 'psychologically disorganised individuals' and to those with 'weak egos':

The untutored person in Malay society, especially in the case of females, is a shy, retiring, unaggressive, self-effacing changeable and colourless person, with little individuality (Yap 1952:553).

Using a more explicit evolutionary (racist and sexist) paradigm, another colonial observer explained fright reactions and assumed higher frequencies among women thus:

...The higher a people is civilised, the more controlled are its affect-reactions; we also see the more intellectually developed individual stand farther away from the 'wild' type than the undeveloped. These latter have a more 'infantile' way of reacting; therefore the civilised man stands farthest away; the woman whose entire psyche remains at a more infantile stage than that of the man (strongly emotional, suggestive etc.), in the same way shows a stronger affect reaction. Thus it is not surprising that especially the primitive woman of the lower classes shows pathological anomalies in this direction... (van Loon 1924:315).

In an article entitled 'Contributions to the Knowledge of Indian Psychoses', Theunissen posited 'important differences' between 'less developed people' and 'more cultured man' and concluded that 'from an intellectual point of view' the average native mind was inferior to the European, being 'slow and poor in ideas' (1921:79, 85). Furthermore, he maintained that the natives' apprehensions about evil spirits were relevant to their character and their mental diseases. Nevertheless, he held that intoxication and infection were the direct cause of psychoses (Theunissen, 1921:81).

Apparently, the odd neurologist who happened upon the scene classified *latab* as a neurological disease (due to degeneration of the brain) and thereby, in Yap's judgement, departed from intelligent psychological speculation which emphasised the common initial 'sexual' or 'phallic' dream about dismembered, erect and gross penises (1952:524). Freudian interpretations argued that the dream, its imagery and imputed cause (sexual frustration and repression) were precipitating factors in the emergence of *latab*. But this seems to me to confuse the effect with the cause as vivid, frightening dreams can constitute prodromal symptoms of organic psychosis. Like Kenny (1978), I would also relate the significance of the initial disturbing dream content to local constructions of disease spirits and magical symbolism. Interestingly, in an earlier colonial observation, sexual repression was not seen to be an issue:

There might be said a good deal about the erotic manifestations of the confusional Malay: I only will mention that very frank utterance is given to all his erotic thoughts, that however onanism is seen very seldom indeed. Perhaps a consequence of the absence of repression? (van Loon 1922:218).

Chance observations of colonial medical and administrative personnel, visitors and ethnographers do not constitute epidemiological data. Yet from such sources the accepted pronouncements are that: *latab* occurs

primarily among Malays and there are higher frequency rates among women; those in subservient social positions are more vulnerable. Little substantive material or new data have been forthcoming, although various interpretations have been made.

Hildred Geertz, for example, has argued that *latab* is congruent with Javanese culture; the symptomatology is determined by cultural tradition and is 'unconsciously meaningful' as an inversion of Javanese cultural values and ideals of appropriate behaviour. She also asserts that Javanese women do not endure a subservient position or play a restricted role. Most Javanese women, including those who suffer *latab*, are self-confident and assertive (Geertz 1968:103). Pfeiffer on the other hand, reproduces a cultural stereotype - the submissive, inert torpid character of the Malay race in general and of the Malay woman in particular. He detected a parallel between the surrender and passivity of the *latab* state and his image of the Javanese woman (1968:37).

Rejecting the 'disease' model of *latab* and discounting possible bio-medical elements, Kenny (1978, 1983) defined *latab* as a cultural reaction to low status and social marginality and a means of overcoming them. Thus he perceived it as a 'putative mental disorder' rooted in Javanese metaphysical conceptions. Having rejected biological determinants in *latab*, Kenny argued that it was primarily theatre performance, dramatic mimesis or parody of social norms by lower status women; a kind of socially-sanctioned obscenity in contrast to culturally preferred refinement. Thus, he saw *latab* symptomatology as a 'peculiarly appropriate means of communicating... marginality to others' and a device whereby lower status and distress are acknowledged and surmounted (Kenny 1983:160.)

Murphy attempted a quasi-epidemiological study of both *latab* and *amok* in order to demonstrate his hypothesis that they are by-products of social problem-solving, tending to increase when the imperative for adaptive change was highest:

...*latab* appeared relatively suddenly during the second half of the nineteenth century, spread quite rapidly among the populations most exposed to European influence, and then moved in a wave fashion away from these centres, so that today it is virtually absent in the locations where it was first observed but is present in more distant locations where it was previously absent... and in areas from which it is disappearing the residual subjects seem less intelligent than the earlier ones (1972:47).

With a limited understanding of the phenomena, and on the basis of outsiders' fortuitous encounters with clinical cases, can we know anything significant concerning the incidence and prevalence of *latab* or of age and

sex frequencies? Can we judge the whole from a limited knowledge of a small unrepresentative sample of the population? As Leighton has commented, the epidemiologic work on these disorders is weak to non-existent. Estimations of frequency are vague. When numbers are used they are 'numerators without denominators' (1982:217). The finding that there are high rates of mental disorder among the lower socio-economic levels of society may say more about the composition of the population than anything else. Moreover, the observers disagree (cf. Geertz 1958; Kenny 1983; Simons 1980).

Yet, among the various Asian populations in which culture-bound syndromes have been observed there is a marked similarity in symptomatology, a combination of non-neurological and neurological symptoms and signs. This symptomatology as described in case studies, together with that of *babaman* described in local medical sources, seems to me to indicate more a universal human neuropathological potential (cf. Sechrest 1969:329; Simons 1980) than conformity to a pattern of 'madness' resulting from cultural sanctions and predilections. That the syndromes occur among peoples with comparable technologies, who face similar forms of environmental stress, high rates of morbidity and low standards of hygiene could be vital analytical data. Yet, from the narrow perspective of psychodynamic formulations, one could gain the erroneous impression that among the populations of Southeast Asia there is an inordinate number of hysterical paranoid, neurotic hypochondriacal maniacs who are predisposed to a poor tolerance of anxiety, who tend to express their emotional tensions somatically and act out unresolved discontents through flights of aggressive passion, panic or fatuous euphoria (cf. Stoller 1969; Obeyesekere 1979).

Against views which deny a place to neurophysiology in the genesis and expression of *latab*, I would argue that *latab* behaviour, like the mental symptoms displayed in *babaman*, constitutes a radical departure from social norms and standards of etiquette in any culture. Admittedly, feigned or simulated insanity, mental or social distress might account for some cases of diagnosed *latab* and *babaman* but not for all the individuals so affected, or for the *babaman* syndrome itself as it is described in local medical treatises. Judgement, self-control and discernment are as highly valued in Asian societies as they are elsewhere. Loss of control or awareness and disorientation are not states to which people normally aspire. The notion of women taking recourse to bizarre behaviour indicative of mental derangement to improve their lot, does not even sound logical. Besides, what exactly are the afflicted supposed to gain from feigned derangement? Most are long term sufferers. They do not enjoy it. In fact, the afflicted suffer extreme discomfort and helplessness, according to Yap (1952:550). Moreover, the behavioural symptoms appear to relate to

activities of the brain, and the *latab* predicament broaches as many (or more) problems for the sufferers as it could possibly resolve. If repressive social structures and interpersonal conflict (the salience of which is not doubted) were conducive to the genesis of culture-bound syndromes and their symptomatology, one might perhaps expect even higher incidences of them. I dare say many observed *latab* sufferers were experiencing problematic social relationships and stress at the time of affliction. Few people in any culture secure for themselves a stress-free existence.

(v) *Models of Madness; Paradigms and Platitudes*

The 'outlandish' races discovered through colonial penetrations became the objects of European efforts to define mental disturbance among 'more civilised races'. Thus Sigmund Freud wrote:

Primitive man is known to us by the stages of development through which he has passed... and through remnants of his ways of thinking that survive in our own manners and customs. Moreover, in a certain sense he is still our contemporary: there are people whom we still consider more closely related to primitive man than to ourselves, in whom we therefore recognise the direct descendants and representatives of earlier man. We can thus judge the so-called savage and semi-savage races; their psychic life assumes a peculiar interest for us, for we can recognise in their psychic life a well-preserved, early stage of our own development (1938:15).

Freud posited correspondences between taboo customs and the symptoms of compulsive neurosis (1938:48). Decades later, analogies and comparisons using an evolutionary framework were still asserted, as the following statement from Yap indicates:

We must finally mention an important psychiatric generalisation which affirms that there is an analogy between schizophrenic and primitive ways of thought... the *analogy* between primitive savage thinking and the regressed schizophrenic thinking is often striking (1951:324).

Both psychiatric and a significant proportion of anthropological research in Asia was initiated for the purpose of studying cultural influences on the frequency and symptomatology of mental disorders. In some quarters the physical and biochemical differences between population groups, used as criteria for racial classifications, came to be regarded as having psychological implications and intellectual and behavioural correspondences. For example, anthropological research on Bali conducted by Bateson, Mead and Belo was initiated by a request from the Committee for the Study of Dementia Praecox (now called schizophrenia) for a cultural study which could lead to a better understanding of the condition. A reconnaissance of Balinese mental health was also part of the objective. The choice of Bali for this comparative study was determined by the

presupposition that the culture was one in which a significant percentage of the population, while exhibiting many of the overt behavioural characteristics and 'test responses' associated with schizophrenia in Western cultures, were able to lead normal lives and function within the dissociated mode of functioning expected in that society (cf. Belo 1970; Bateson 1970; Mead 1970, 1979).

These researchers maintained that, in the study of Balinese trance and ritual, they had encountered thought processes of the same order as those which psychoanalysts had described in schizophrenics and likened to primitive archaic thought. Beklo (1970) applied performance tests to trance mediums in order to see if the tendency to think in 'complexes' characteristic of schizophrenics, was also a tendency among Balinese trance subjects. Mead and Bateson described psychopathological tendencies, posited cultural, child-rearing and socialisation techniques (such as teasing and withdrawing) as causal factors in psychogenesis, designating them as standard forms of emotional release or repressed aggression (Mead 1970, 1979; Bateson 1970).

Mental illness has captured the imagination of those for whom the poignancy and spectacle of clinical manifestations of dysfunction of the nervous system are no longer a conspicuous part of their pattern of morbidity. Indeed, madness has been assigned a peculiar status by the Western social scientific industry: as Derrida comments, Foucault aspires to capture 'untamed madness'... 'in its most vibrant state' rejecting bio-medical data in favour of popular notions from unverifiable sources (Derrida 1981:34).

In a critique of Freud and trends in psychoanalytical theory, Brewer suggests an alarmingly simple reason for the preeminence of psychodynamic theories and the non-assertiveness of the neuropathologic view:

The phrase 'the devil has all the best tunes' was surely created with Freud and his disciples in mind. Who could hope to compete with penis envy, castration anxiety... (1982:685).

and, I would add, with catchy cliches like Laing's 'the blessed mad with special insight', 'culturally-sanctioned escape-hatches for the repressed', or 'flight into illness'. For those who choose to reject a bio-medical paradigm in the study of mental illness, variations on the Laingian credo - do not adjust your brain, there is something wrong with your racial, mental endowment, your culture or your society's philosophical assumptions - legitimate this stance. Does the conspiracy implicit in the trend of the 1960s that 'the brain, uniquely among all organs, does not go wrong' (Brewer 1982:686) remain?

Encapsulated within a metaphysical aetiology, the Balinese do have a

medical model of madness. Neurological and non-neurological diseases share similar aetiological options and metaphysical and pathological mechanisms. Impairment of the faculties of intellect and judgement, loss of control, inability to differentiate the appropriateness of behaviour and speech (madness and insanity in latter-day terminology) are locally defined as abnormal and of the same order as somatic symptoms of disease. Such symptomatology is generically labelled *edan* and *budub*. It may occur as a phase of other generic categories (e.g. of *tuju* or *twang*) or in the febrile phase of any illness. All abnormality, whether primarily affecting the physical component of the body or mind, is termed illness (*gering*). Balinese concepts of mental disturbance share a perspective found in classical Ayurvedic theory wherein mental derangement is explained without any reference whatsoever to psychodynamic theory (cf. Obeysekere 1977:161). The intrusion of pathological agents (however they are perceived) is the basis of disordered mental function. *Edan* (or *budub*) is a potential phase in any dynamic morbid process and it is dominant in some forms of disease. While there is no obvious description of mental derangement due to brain lesions, there is a theory of pathogens (be they a *babai* or those responsible for *twang*, for example) moving to the head, the location of mind, language ability, perception and cognition, and precipitating disturbance and disorganisation.

Balinese medical theory does not have a category of mental disorders of a psychogenic origin corresponding to neurosis, phobia, hysteria, paranoia, fear psychosis and hypochondriasis. States of fear, anxiety, depression and agitation are normal reactions to life's stresses. Prolonged exacerbation of these natural states for no apparent reason are not labelled deviant or abnormal psychological reactions. On the mind-body issue, Balinese medical theory shares the neurologist's position of psychophysical monism. There is no mind/body dichotomy. In Balinese medical theory, the mind is an inseparable part of the living organism. It does not exist independently of the body (or act against it). The soul is another matter.

Madness (*edan*) can afflict any group, including infants, a matter which should undermine the notion of psychosocial origins of mental symptoms like fright, listlessness or abnormal grasping and groping. Of course the range of abnormality of affective, perceptive and cognitive experience an infant can express is limited. The point being made is that Balinese medical theory does not differentiate linguistically or conceptually between 'madness' expressed in a person running berserk, displaying aphasia or other forms of behaviour characteristic of culture-bound syndromes, and blurred consciousness or loss of consciousness which are clearly indicative of neuropathological defined disease.

I am not arguing that nature, in the sense of neuropathology, is an ex-

clusive alternative to socio-cultural factors in explanation. Obviously, specific behaviour patterns, life-styles and ritual practices influence the content of symptomatology and, to some extent, account for the degree of conformity displayed in the syndromes. An individual sustaining a grave assault to the central nervous system in an urban Western society is unlikely to scramble up a tree to evade would-be captors, to flourish a kris or to hallucinate the fantastic images peculiar to the Balinese visual landscape and iconography. Indeed, the vocabulary of madness does have a strong cultural content. The abnormality of such behaviour is defined only by the inappropriateness, undirectedness or excessiveness of the activity. To run amok and stab one's opponents and finally oneself on a battlefield is not classified as madness. To run amok as an individual without any apparent cause is abnormality indicative of pathology. When Javanese and Balinese act with undirected, unprovoked hostility and run amok, they often do so with a kris. However, the form of this disorganisation pertains to brain activity. Because the symptomatology of mental disorder is expressed in a cultural idiom and reflects metaphysical assumptions, the condition is not explicable simply in cultural terms (cf. Leighton 1982:219-20). Such an explanation draws attention away from the actuality of disease problems facing peoples of Asia and focuses upon the imputed proclivity of 'culture-types' to express dissatisfaction and aggression through feigned affliction, and to somatize mental distress. Notwithstanding the cultural elaborations woven around *babaman*, the syndrome itself is not simply a product of culture. Disease is mediated through a system of symbols (call it culture) but the nature of the pathogen directs the form which cultural representations (the symbolism) take. This is the reason why *babaman* is constructed differently in Bali from, say, smallpox or leprosy.

What also needs to be addressed are the politics of medical research which are directed largely towards the artificial prolongation of the lives of the more affluent while diseases afflicting the mass of the world's population thrive. Too much emphasis on the role of culture and the imputed psychosocial tendencies of Third World population groups, whose diseases present with mental symptoms, shirks consideration of the ecology of poverty and of survival in a harsh tropical and unsanitary environment. The human neurological system is particularly susceptible to damage from nutritional deficiencies and to infections that are rife in such an environment. There is accumulating evidence that foetal and infantile malnutrition, anaemia (resulting from parasitic infections) and catastrophic infections associated with febrile convulsions have a deleterious effect upon the developing brain that time does not heal. Acute and chronic infections can present with behavioural disturbances when lesions occur in the frontal lobes of the brain. Vitamin deficiencies and malnutrition can present as acute organic psychoses. Infection-induced psychoses are also likely to be more prominent in tropical Southeast Asia than in temperate regions (Orley and Tsuang 1983:24-48). Most infectious diseases interfere

with the body's intake of food and capacity to absorb it. Malnutrition then lowers resistance to infections. Although genetic susceptibility may also be pertinent, nutritional deficiency has contributed to various (obscure) neuropathies. The notion of a 'lethal synthesis', for example, in people suffering malaria, parasitic disease, infections and malnutrition, could be relevant to the aetiology of the not-yet-understood phenomena that are the subject matter of this paper.

It is suggested that because Western observers described certain 'bizarre' (unfamiliar) syndromes among 'exotic' (other) Asian populations, there was little inhibition to their constructing a set of 'atypical reactive psychoses' which made sense to Western psychiatric nosology'; associated exotica were then attributed first to racial personality and intelligence and later to 'culture personality'.

Accounts of culture-bound syndromes such as *latab* are worthy of a study in their own right insofar as they reveal a shift from the renounced racial-determinist arguments to cultural-determinist ones wherein the content of the imputed contributing factors remain basically unchanged. In the first, there is a racial type in a 'lower' evolutionary stage of psychical development and vulnerable to 'imbecility' and 'primitive reactions' in the presence of 'more cultured races'. In the second, there is a 'cultural personality' predisposed to feigning forms of madness in order to cope with crises and repression. Anthropological research in this area in particular highlights the nurture-over-nature triumph to which Freeman (1983) refers. Culture, that 'common-sense' factor in human experience (cf. Geertz 1983), is allegedly maladaptive, even pathogenic.

My argument is that this produces cultural stereotyping along the lines once rightly condemned as racial stereotyping. The same data have been used to draw conclusions which reflect the disciplinary interests and commitments of the particular researcher, as well as the changing aetiologic view - culture not race - of Western academic enterprise. This has meant little expansion in knowledge of Asian medical problems or experience. Granted the present state of our knowledge of tropical neurology, the use of the phrase culture-bound syndrome, in the acquired sense of culture-induced, seems to me racist and prejudicial to Asian populations, even if unintentionally so.

Although a consideration of the effects of culture, in the sense of customs of life-style, on the transmission of disease may be justified, there is good reason to be cautious with formulations which arraign culture as causative,

at least until further studies of tropical neurology have been undertaken and local medical knowledge has been examined.

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