

Culture, Structure and Mental Disorder*

by

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1. THEORY

There seems to be general agreement today that etiology/epidemiology of mental disorder can only be explored in a multidisciplinary manner. More particularly, since the sciences involved can be arranged according to levels of system organization they study, this implies a multilevel approach. At the bottom of the hierarchic levels physical and chemical factors are considered; then follows a level where organisms as vectors of disease are examined (the virus perhaps being located between these two levels); then comes an individualizing level where the individual human being is seen as not only the carrier but also the source of disease or ill-health in any form, e.g. because of sins committed, or "break-downs", usually studied longitudinally, investigating the pathological process throughout the individual life-span; then comes a micro-societal level where determinants are found in the immediate social surroundings of the diseased person, usually the family; followed by macro-societal levels where the general social characteristics of the entire society are taken into consideration; and, finally, there is a cultural level of abstraction which recently has been accorded more significance.

Thus, in terms of disciplines this would span from basic natural sciences to humanistic sciences, from highly individualizing psychological approaches via socio-psychological conceptions to sociological, even international relations oriented approaches. Needless to say, the person who commands this span of disciplines, and in addition has sufficient insight to comprehend the dependent variable (the process health to unhealth and back

again), does not exist. The multidisciplinary or multilevel approach calls for a collective method of exploration, often referred to as teamwork, and not only at the analytical/theoretical level, but also in all types of preventive and curative practice. This trivial observation has some implications that will be explored below, but first some reflections on the idea of hierarchy levels mentioned above.

First, it should be noted that there is a certain asymmetry between the ways in which the independent and dependent variables are approached. In the centre of attention are human beings, but in a restricted sense: "health-unhealth" as phenomena commonly conceived of are seen as characteristics of individuals, but to understand the conditions of "health-unhealth", a multiplicity of levels is drawn upon. The health focus is anthropocentric; the concern is with the health of man, not with the health of nature, the bio-sphere in general, the health of families, of societies or cultures. There is also a tendency to regard such expressions as "a healthy society" as a value-judgement whereas the characterization of human beings as healthy or unhealthy is taken to be less problematic, although there is a grey zone between the more extreme parts of the human health-unhealth spectrum. This is important because it is reflected in an asymmetry between the medical part and other parts of the teams mentioned above. The others enter as auxiliaries, as helpers; medical man constitutes the ultimate integrative focus in the total system, having more insight - presumably - in the dependent variable by monopolizing the idea and precise definitions of disease, and by focussing it all on individual health-careers.

Second, the causal arrows in the various models have a tendency to become undirectional, in spite of protestations to the contrary. Man is seen as a victim of evil forces, with earthquakes, toxic substances, virus, bacteria and other organisms, carrying diseases constituting basic factors out of which the model of man as a victim has been constructed. There is probably a certain carry-over from this paradigm to other and more recent levels in a multilevel approach: man is also seen as a victim of his own infancy and early childhood and early experiences in general of micro-societal forces, of macro-societal

forces and of the cultural setting in which he lives. He is seen more as an object, less as a subject of his own disease. This is important because there will easily be a direct carry-over from this way of viewing the healthy-unhealthy transition to the way of viewing the unhealthy-healthy transition: as the consequence of the actions engaged in by curers and healers of various kinds, not of one's own activity. Man is not in general seen as cause of his own health-unhealth-health cycle.

Of course, historically there was, and partly is, an extremely important exception to this, inserting between man and the agents of disease and health a transcendental factor sometimes punishing man for his sins, occasionally rewarding him by paying attention to his prayers to be cured. There is a more secular parallel in our times, "personal hygiene", but only relative to one of the levels in the hierarchy above. In general the victim image prevails. We mention such factors as these in order to try to proceed with care: it is usually in the very basic assumption that something interesting may be located. Thus, one fundamental and relatively reasonable hypothesis that has gained considerable attention in recent years is that the structure of health care is to some extent a function of our deeper, underlying theories about health. This will be discussed later after a presentation of the four last levels in the hierarchy of levels, the "social science" levels, in a generalized sense.

They range from the individual microcosm to high level cultural abstractions expressed as values and norms, ideas and conceptions; or, in the approach that we shall use, as basic, often implicit, notions about reality in general and social reality in particular, in other words social cosmology. The basic question to be asked would be: where on the micro-macro spectrum would the socially acceptable explanation for mental ill-health or disorder be located? Intuitively one would say as close to the individual micro-level as possible, for two reasons.

First, the lower the level, the more manipulable the factors surrounding the individual, or at least so one believes. Second, the higher the level, the more basic, the more fundamental the

approach to disease. Thus, one thing is to find important factors associated with schizophrenia¹⁾ in the bio-genetic and/or socio/cultural family structure of the patient himself; quite another to locate a factor in the entire "Western culture". It is not only that change in the family structure of particularly exposed individuals, including bio-genetic manipulation/isolation, is more feasible than changes in Western social cosmology; it is also that we are all parts of the latter whereas only the schizophrenic patient is a part of the former. To locate some of the total causal material, so to speak, outside the micro-environment of the diseased person, even so as to include all or most of us, not only means that we are all exposed, and possibly included in the cycle, but also that there may be something basically wrong with the fundamental pillars of the entire system. It even leads to the disturbing question of whether those who control the means of production of health, are themselves healthy? And if they are not, what implications does it have for their definition and production of health? Do they, for instance, define health in their own image? 2)

Thus, to dislocate the point of ethiological gravity in the distribution of the causal factors upwards in a hierarchy of levels is a dramatic act, likely to be resisted by the protagonists of the system, and as likely to be indulged in, relished by antagonists to the system. In short, whether we do so or not, we are close to some kind of politics; which is neither good nor bad in itself, but somewhat problematic and for that reason avoided by many.

Let us now divide the four levels in two. The bottom two micro-levels can be referred to as the psycho-social approach; and the top two macro-levels may be referred to as the structural-cultural approach. Needless to say, the two are related: the structural-cultural presupposes psycho-social approaches, and vice-versa. But there are some important differences that can be illustrated by the following examples. Thus, imagine that the family structure is taken as an independent variable, some symptoms of psychosocial disorders as dependent variable, and that a high correlation is found between incomplete, broken, disorganized family structures whereby individuals are left much

alone without adequate emotional ties and human experiences on the one hand; and on the other hand the symptoms of schizophrenia or other mental disorders.³⁾ This would be related to an effort to establish a typology of families, ranging from the image just given to the complete, cohesive, stable and rich family life providing not only support but also experience, warmth and challenge.

In the psychosocial approach the analysis would probably stop there; the translation from correlation to causation would be a relatively quick one. But in the structural-cultural approach one would go one step further and perhaps reason as follows. There is something in general in big structures and cultures that constitutes a very heavy strain on individuals. However, most individuals are also equipped with some kind of "protective cocoon", meaning a cohesive little collectivity, with a high level of permissiveness if one wants to indulge in some type of regression towards childhood behaviour, for shorter or longer periods, with skin to skin physical closeness, with love and sex. In Western culture this is provided, presumably, by the nuclear family. The protective cocoon is somehow like the ozone layer relative to ultraviolet rays from outer space: where the layer is intact, the damage is minimal; where the layer is broken, the damage may be lethal.

The difference between the two perspectives is important in several respects. The psychosocial familistic view would focus preventive and curative attention on the family in the form of the various social worker approaches, in order to bring about some family reorganization. The obvious consideration that people live only a limited period of their daily, weekly, monthly and annual cycles protected by the family, when it offers protection that is, will tend to be left out. A focus on the overall social structure would have as a possible implication that we are all to some extent unhealthy, only incapable of defining ourselves that way because we do not see ourselves from the outside, and because of vested interest in defining ourselves as healthy. By focussing on the structural aspects of the family one conveniently does not focus on other social

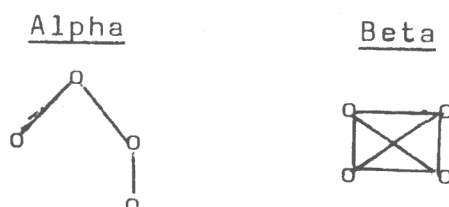
structures, among them also the structure of medical care. A familistic approach relegates structural thinking to corners of society, although, admitted, to very important parts. A more comprehensive structural approach would make a neat distinction between healthy and unhealthy much more problematic, including - as mentioned - the physician's claim to be healthy - if that is considered a condition for curing others. But pin-point cure would no longer be possible - what would be called for would be a more comprehensive structural-cultural change.

This, then, leads to the question of how to categorize structures and cultures, starting with structure. The approach taken here is a very simple one, dividing social structures as to whether they are "vertical" or "horizontal", "big" or "small":⁴⁾

Table 1. A Typology of Social Structures

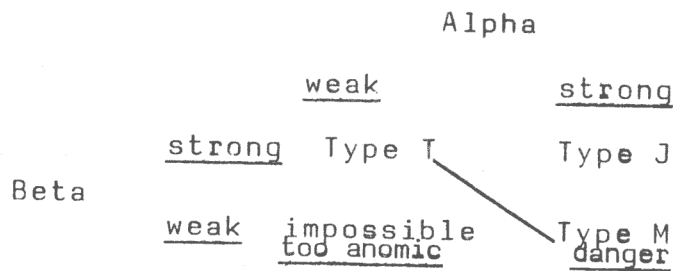
	<u>Big</u>	<u>Small</u>
<u>Vertical</u>	Alpha	Gamma
<u>Horizontal</u>	Impossible	Beta

The vertical/horizontal distinction, then, is seen in terms of differences in power and privilege produced by an inequitable (exploitative) structure, and the big/small distinction in terms of whether direct, person-to-person interaction is possible or not. If the structure is to be horizontal, meaning symmetric, leaving nobody out, everybody relating with much of their person, not only with a little fragment, then the structure cannot be big because of the limited interaction capacity of human beings. Vertical goes with smallness as in highly pater familias dominated families, but also with bigness - as in bureaucracies, corporations, giant universities and all their international counterparts. Diagrammatically they look something like this:



In any concrete society we find both alpha and beta structures; individuals are members of both (we disregard gamma for the sake of convenience). Alpha is strong in societies with bureaucratic/corporate structures well articulated; beta strong in societies with family/kinship/friendship etc. groups well articulated. A society can be strong on either but cannot be weak on both, it has to have some structure. This gives us the following possibilities:

Table 2. A Typology of Societies



Type T is what in development literature was called "traditional" society: The superstructure weak, micro-levels strong. Type M is the "modern" society: alpha predominant in its bureaucratic (nation-building!) and corporate (economic growth!) manifestations, beta weakened in the process, people exposed to alpha pressures, deprived of many of the beta network support - the "protective cocoon" of the family included. By itself is Type J - Japan - which seems to have been able to develop very strong alpha structures, yet keeping strong beta types - like groups of people who entered school/company together.

Obviously we would tend to see Type M as the most exposed one threatening people's identity by incorporating them in vast marginalizing, fragmenting and segmenting structures while at the same time depriving them of direct personal support. In other words, "development" seen as traditional → modern transition, increases the vulnerability of the individual, and not because of the process of change as such, because of the end result.⁵⁾ If Japan is - so far - the exception to this, then it is because of its ability to find another development trajectory, using groups (beta or gamma) as building blocs in their alpha structures rather than individuals.

This general perspective is consistent both with the general

findings that ⁶⁾

- mental disorder increases with breakdown of families, networks, etc.
- mental disorder increases with increasing modernization/industrialization-"development" in the conventional sense.

The question is whether there is an interaction effect; whether isolated individuals are (much) more hit in modern structures than one might surmise by adding the two factors in Type M. And one place to study this combination would be the mental hospital itself.^{6a)}

Another question would be in terms of action consequences, to decrease vulnerability. Some people would prefer to strengthen the beta structure around themselves - collectivities, teamwork on the job etc. - others would prefer to weaken the alpha structure - decentralization, smaller units, etc. In all of this one recognizes the general ethos of the green movements in Type M (roughly OECD countries with the exception of Japan) - as movements of defense against excessive strain rather than as aggressive, revolutionary movements.⁷⁾

One may say that the micro-societal approach captures only the beta-disintegration aspect and not the general relation to the alpha/beta dialectic known as "development". And the macro-societal approach captures only the alpha-integration aspect. These processes have to be seen conjointly, among other reasons because they are logically independent of each other even though they are empirically correlated - as Table 2 indicates.

Let us then turn to culture to see whether a vocabulary relevant for problems of mental disorder could be suggested also in this field. The point of departure, then, is that culture is not seen as a set of objects, "arte-facts" as ethnographers might say, nor as a set of behavioural rules as social anthropologists might do. These approaches are invaluable, but the effort here is to go deeper and try to see culture in terms of deeply located conceptions of social reality; in other words as "social cosmology"⁸⁾ More particularly, we shall try to say something about conceptions of space, of time, of knowledge, of person-person relations and person-nature relations.

We shall follow the conventional approach of emphasizing Western culture, but with no assumption that there is any kind of unity to everything non-Western; nor that some, even many, of the features held to be typical of Western culture or social cosmology cannot also be found in other cultures. It is the combination of all five that, perhaps, may be said to be "Western" - or "occidental".

To start with space: it is assumed that Western man has a tendency to see space as a circle or a sphere (the more sophisticated ones would add more than three dimensions to the description), with its centre located in the West - which is seen as pluralistic, with the centre of control moving from one place to the other through time - and with a vast periphery. It may be objected that other societies and cultures also see themselves as the centre of the universe. But typical of the Western conceptualization are probably two things: there is no limit anywhere, no pocket in geography outside which there is no periphery, but irrelevance. Second, it is seen as a right and indeed as a duty of the West to support, even stimulate, processes whereby the periphery becomes more similar to the centre in so far as this is possible without the centre losing its character as centre. One can find this basic idea clearly expressed in the organizations of Western empires, from the Roman empire till today; in city planning with distinct centres and avenues and highways radiating from the centre, and so on. It is an extrovert, outward-looking, expanding, even aggressive type of culture.

From the point of view of mental health one might now surmise that this has at least two important consequences: a feeling that space does not have any closure, that there is no end to one's concern, no simple cutting point beyond which irrelevance starts. The idea that the centre-periphery structure is somehow the normal structure, leads to the strains of overdevelopment in the centre and underdevelopment in the periphery - well known from recent literature in the field of political economics - but at the same time to the idea that any change in the basic centre-periphery structure would be contrary to the natural order. In the microcosm of the family this is seen very clearly:

the centre-periphery division of labour between husband and wife, and between parents and children, itself leads to stresses and strains; efforts to upset it lead to other types of stresses and strains because of the strong feeling that centralizing division of labour is the "natural" form. Thus, we would predict much mental breakdown in the centre when the periphery revolts not merely because of loss of power and privilege, but because of the feeling that the world is coming to an end - that unnatural processes are at work. The discrepancy between the Western mental map of the world in clear centre-periphery terms and the real world that is now taking shape may constitute a tremendous mental threat. The impact of that remains to be seen. 9)

Similarly with time: there seems to be a relatively clearly identifiable Western pattern. More particularly, this pattern probably includes several components, such as the idea of a Paradise once upon a time, then the Paradise was lost through the Fall, then came the Dark Ages, then the Enlightenment, then the period of Progress. But ahead of us there is a Crisis, and we have to go through that crisis before paradise will be regained, before catharsis is ushered in. This is not the place to argue in detail, suffice it only to say that this paradigm of how things take place in time would be seen as applicable to human history as a whole, to Western history, to the history of single nation states and to the history of the family and the individual's own autobiography. The basic idea would be not only that one has to go through some kind of fundamental crisis in order to receive fulfilment, but also that there is one such crisis in the life of the individual, family, the nations, the states, etc.

Thus, in Western career patterns today the crisis period is probably around the age of 30, may be earlier, may be later: the period of break-through for the ambitious, achievement-oriented person. If he has not "made it" by that time, chances are he never will. But the point is that he himself, if he is a true Westerner, will probably have no feeling of having mastered the crisis so as to enjoy catharsis. Rather, he will see new crisis ahead, constantly building up, calling for renewed effort and attention, even increasingly so. Thus an unending pressure for

achievement and crisis preparation is built up, making death (and mental disorder) the only and ultimate escape into catharsis. This should then be contrasted with the Japanese pattern where a tremendous pressure is concentrated on the young person in his late teens or early twenties (the famous entrance examinations), but after that (and before it) there is considerable relaxation and protection. Another contrast would be provided by the less achievement-oriented cultures in general. With the giant transformation now coming under the code name of The New International Economic Order, not only the world map but also the individual map of their own career patterns as prescribed by the culture may be severely unrealistic. The discrepancy, again may have serious mental health implications. In what could be referred to as the Western way of conceiving of social processes, there are many components, e.g. process as sorting, the good from the evil, the clever from the less clever, those of one colour from those of another colour, not to mention the healthy from the unhealthy. This is linked to ideas of centre-periphery and ideas of progress, crisis and catharsis: gradually the centre will become more and more perfect, it will expand and incorporate more and more of the periphery; the process will accelerate but there will be terrible resistance before the final triumph. Ideas like these are often found in the types of Christianity, liberalism and marxism referred to as "vulgar" or "dogmatic", leading to the important question of whether there is some underlying Western form or mould that could take almost any ideology and convert it into something compatible with the three elements already mentioned. Thus, it is important to note that whereas Christianity started as a periphery religion, providing protection and a social outlook for the downtrodden, it relatively quickly became the ideology of the centre, not unlike Marxism in the middle of this century.

An important mental health implication of this basic assumption in the field of knowledge, epistemology, seems clear: the notion of purity, of sharp borderlines between health and

unhealth. The contrast would be provided by more dialectically oriented cultures, e.g. by the Chinese Yin/Yang tradition which would deny that anything, including human beings, can be reliable and permanently sorted into positive and negative categories; or even conceivable in such clear categories. Just to the contrary, the emphasis would be on the idea that health is always accompanied by unhealth and unhealth always by health. In Western culture the healthy would have a tendency not to recognize his unhealthy components and the unhealthy to belittle or disbelieve his own potentials for health. The partially crippled will focus all his attention on the faulty limb and develop blindness to the 95% of the body that may be functioning perfectly, and be supported in this distorted perspective by an environment that tends to perceive things the same way. When this is even institutionalized into special types of buildings and areas for the non-healthy, hospitals, the sorting process has been carried far¹⁰⁾ although not to its ultimate consequence which would be the elimination of the unhealthy - the Nazi solution (but also practised in several non-Western cultures, although perhaps more in times of economic distress and scarcity than out of principle. The Nazis did not do it for economic reasons). The tolerance/intolerance border becomes very sharply drawn, too sharp for the mental well-being of people sensitive to their own imperfections.

There also seems to be some kind of person-over-person principle built into Western culture. Verticality is certainly found in many social structures, but there is one aspect that is particularly important here: the idea that conflict can best be resolved, or should be resolved, by some kind of process whereby one party wins over the other. The idea of reaching consensus, of striving for a harmony, is not alien to Western culture, but certainly not the dominant factor either. Processes like debates, court procedures, elections, not to mention battles and wars are typical examples of how the person-over-person principle is brought into conflict resolution.¹¹⁾ From a mental health point of view this has clear implications: if there are winners, there are also losers. One would tend to imagine that losers would be overrepresented among the patients of any kind,

although the strains brought upon the winners should also be considerable (thus, the correlation would not be perfect). Since Western vertical social structure can be seen as an institutionalization of this winner-loser principle, as some kind of almost geological sedimentation of layers of new winners on top of preceding generations of winners, one would expect relatively high correlation with vertical social position in general, with mental strains showing up at the bottom. It should also be pointed out that this may be one way of dealing with the losers in the conflicts, through institutionalization as diseased persons. Another way might be to marginalize them through underemployment, possibly even to combine the two by putting so much pressure on the bottom of society that otherwise unemployed become institutionalized as mentally ill. And this also relates to sickness theory: causal theories emphasizing factors that hit the individual will be most credible in Western thinking because they serve to sort the good from the bad, and establish a hegemony of healthy individuals over the non-healthy.

Then, there is the person-over-nature principle: the idea that man has not only a right but also a duty to make nature serve his needs. There is an asymmetry in the relation between man and nature: one is master, the other is slave, it is a master-slave relation rather than a partnership relation. This is then tied to all the other four principles above: nature is brought into the centre-periphery relationship in the structure of trade; the idea of progress is translated into economic growth at the expense of nature; the idea of sorting into the idea of processing of raw materials; the person-over-person principle into the competitive patterns of economic relations, all of it constituting what we know today as the predominant social structure of the world.

But there is also an immediate mental health implication of which we probably know very little: an increasing distance between human beings and nature. Since we are part of nature one would imagine that this cannot take place without doing some fundamental harm to our well-being: to be closed off from a part of ourselves cannot but have important consequences. One particular implication may also be that sexuality becomes

overwhelmingly important, as one remaining direct link with something natural - thus putting a tremendous burden on sexual life as regenerating factor. Is sexuality alone capable of substituting for what used to be a more total man-in-nature relation? ¹²⁾

Imagine that one now implements all the five features mentioned above in the way already indicated. The result is a very vertical, centralist and very expansive type of universal social order, in fact what has been referred to above as the alpha social order ("alpha" since it is the dominant social order in the world today). Its negation, a society that is more horizontal, more cohesive, less segmented in general, referred to as the beta social order, would be less compatible: there would be no clear centre and person-over-person ideas - possibly also no domination over nature. One basic insight about "industrialization" can be summarized as follows: Machines, or Western technology in general, are carriers of a certain Western social logic that leads to the alpha system whether under private or state capitalist modes or organizations. But human beings also have their "natural" accompanying social order, and probably closer to the beta variety. The dilemma is that the alpha order is capable of delivering so many goods we have come to appreciate, and can expand in any directions just by adding one more vertical link. The beta order is much richer and denser, but much more limited in its geographical and social extension. We can manage alpha verticality of almost any social magnitude, but beta horizontality becomes strained the moment the order of magnitude of the number of people involved exceeds, say 10^3 or 10^4 . Beta is at its best when the order of magnitude is 10^1 or 10^2 , but not 10^0 - the hermit!

One important point in this connection has been made above: the family as an approximation of the beta social order, serving as a protective cocoon against the macro-societal alpha order surrounding it. Another point can immediately be made: the distinction between the classical doctor-patient relation, perhaps often romanticised, and the modern system of medical treatment, which is uncomfortably close to the alpha order. If the alpha order in itself plays an important role in the

etiology of mental and somatic diseases, one would expect treatment within an alpha system to cause severe ambivalence, possibly with the alpha nature of the system negating many of the curative effects postulated.

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The general line of argument favors the structural-cultural approach, combined with the psycho-social approach - from the individual to the cultural levels. No doubt that reflects the bias of the social scientist incapable of taking into account the bio-physical factors - the physical and chemical factors - the biological organisms and genetical factors. No doubt these enter the picture; no doubt variations in them are also conditioned by human action at all levels. Table 2 above is an effort to combine analyses at the micro- and macro-societal levels. Above it has been pointed out that the alpha/beta balance of a society is conditioned by the underlying social cosmology. At the same time the dependent variable is at the individual level.

One would like to see something much more multi-level. At the very least it should accommodate bio-genetic factors, and the individual should appear also as independent factor - as actor, not only as victim. It is worth noting that criminology and the whole legal/penal tradition is much more actor-oriented, to the point of almost forgetting the victim. It is the doubleness, the actor-victim dialectic, one might like to see included, spinning causal cycles (not chains in the sense of lines!) through all levels of analysis. But so far we shall stick to the simplistic model implicit in Table 2.

2. METHODOLOGY

What kind of research would derive from these considerations? There would be at least two different tasks: a theoretical one which might consist in further elaboration of the cultural and structural characteristics mentioned, possibly subtracting some, possibly adding others. Second, there is the problem of empirical indicators. Some of these indicators could be macro-societal, in the sense of trying to characterize societies and cultures in general. However, for the purpose of this type of research it would probably be better to come closer to the patient and ask such questions as to what extent he and his surroundings are characterized by cultures and structures of the type mentioned and to what extent the general hypothesis of strong alpha penetration through a weakened beta protection would be relevant in his immediate surroundings. Thus, one should be aware of the danger of committing the "ecological fallacy", of reasoning from highly macro-societal and even macro-cultural characteristics to the concrete individual, oblivious of the circumstance that such factors may be relatively irrelevant in his or her surroundings. For in the world today it is very clear that there are underdeveloped pockets (meaning very weak alpha systems) in otherwise overdeveloped countries (meaning very strong alpha systems), and correspondingly overdeveloped pockets in underdeveloped countries. In short, the approach has to be local even if the variables are more global.

One particular type of research that might be interesting in this connection would be to study psychiatrists, in an effort to try to find out how they view the etiology of mental disease. What would be their basic patterns of thinking, patterns that could direct their diagnostic procedures as well as the type of preventive and curative efforts they would go in for? More particularly, to what extent would they themselves be carriers of alpha and beta social orders, and how would their social cosmologies fit in with the social cosmology of their patients?

Roughly speaking the theoretical perspective outlined in the preceding chapter can be summarized in one sentence:

To explore how one cultural and structural environment work on the individual, constituting a balance of forces that may push the individual, so to speak, into patterns of attitude/behaviour identified as symptoms of mental disorder. "Culture" is then seen as a set of values in general and more in particular, implicit rather than explicit, with the focus on deeper values, on what has been referred to as "social cosmology"; and "structure" is seen as concrete social arrangements, as patterns of behaviour more or less consistent with culture. Given the world-encompassing, comparative nature of the project, only two levels surrounding the individual are distinguished: a micro-level close to the individual, typically consisting of family, friends; and a macro-level which covers larger numbers and usually also more geographical territory, and more difficult to identify. It could be the working place, the economic cycle in which the individual is a part, the district, the country, even the region.

In principle this means that for each respondent we want to know something about the cultural and structural environment, both at the macro- and micro-levels. Thus we would like to know not only the more general cultural setting in which the respondent finds himself, but also some of the family cultures, what kinds of expectations he feels he is exposed to in his near milieu. Correspondingly, we would like to have some information not only about how he feels society around him is structured, and how he fits into it, but also about the family or generally primary group unit to which he belongs. With five general cultural dimensions and five general structural dimensions, and with three indicators for each dimension this would yield $2 \times 3 (5 + 5) = 60$ variables for each respondent. That figure is not to be taken too seriously, however. On the one hand there is more information to be obtained from the respondent, for instance about his social position, as distinct from how he perceives the social structure in which he is embedded. And on the other hand there are some of these combinations that are considerably less meaningful than others, they might have to be eliminated.

A study that is international and comparative offers a unique opportunity to test hypotheses about the influence of the cultural/structural environment not only at the individual level, but also at the collective level, meaning the catchment area. This permits analysis where cultural and structural factors can enter provided the catchment areas are well chosen. More particularly, they should be chosen so that they can be ordered along structural or cultural dimensions in a relatively unambiguous manner, for instance according to the degree of industrialization. If that is done in, say, five areas for which there could be 120 orderings out of which the one, factual, empirical ordering may also be reflected in the ordering according to mental health data, one would have a relatively good basis for hypotheses testing.¹³⁾

There are two dimensions of a more structural nature that seem to be particularly important: "capitalist" versus "socialist" ("market economy" versus "centrally planned economy"), and degree of industrialization (sometimes referred to as "developed" versus "developing"). This gives us a total of four combinations, and from a structural point of view it would be useful if all four combinations could be represented. In the IPSS sample of catchment areas there seems to be the usual over-representation of capitalist, industrialized countries (United States, Denmark, Great Britain); in addition to this two industrialized socialist countries (Soviet Union and Czechoslovakia), and then three capitalist less industrialized countries (Nigeria, India, Colombia - but where the latter is concerned it is rather atypical Cali region). It might be argued that it would be useful also to include countries like Mongolia and Cuba (socialist, less industrialized), the People's Republic of China, and perhaps also to add some European countries that are less "developed": for instance Spain among the capitalist countries, and Bulgaria and Poland among the socialist countries. Altogether this would guarantee a range highly sufficient to make for sensitive analyses, particularly of ranking orders.

In a study of the same level of complexity and extension, the Image of the World of the Year 2000¹⁴⁾ study coordinated by the European Coordination Centre for Research and Documentation in Social Sciences, Vienna under the direction of the present

author there were ten countries participating: eight European and two non-European (India and Japan), and the European countries were divided into socialist (Czechoslovakia, Yugoslavia and Poland) and capitalist (Spain, Great Britain, Netherlands, Norway and Finland). However, among the eight European countries, as one will see from the list, there was also the other distinction between more or less industrialized countries, with Spain among the capitalist countries and Poland among the socialist countries clearly in the latter category (for Yugoslavia there was the same problem as for Colombia in the IPSS study: it was actually Slovenia). One conclusion from this study was that the more industrialized/less industrialized distinction proved to be much more important in producing high correlations than the capitalist/socialist distinction - with one important exception: attitudes to foreign affairs. In other words, the populations (and the total number interviewed in the ten countries was close to 9000) seemed to be highly influenced by their developmental surroundings where future perspectives and domestic affairs were concerned, and highly influenced by their government's position where perspectives on international affairs were concerned.¹⁵⁾ This is mentioned here only to indicate that even with a small number of countries interesting conclusions may emerge provided they are sampled in such a way as to span various dimensions.

How can one get the necessary information on catchment areas?

This would no doubt prove to be very difficult. In general one might be inclined to say that there are only two ways of solving the problem of getting some characterizations of the structural and cultural situation in the catchment area: either by having local social scientists trying to characterize the area according to their own variables, e.g. making use of the general framework indicated above, or by looking at the distribution of how the respondents report on the cultural and structural situation. No doubt the averages of these distributions tell something about the "average situation", particularly if these averages are sufficiently dispersed among the

catchment areas and also seem to correspond reasonably well to the data or evaluation given by local scientists.

However, there is one major difficulty: the respondents, mentally unhealthy, are certainly not intended to be a normal sample from the population, for which reason there has to be a control sample if only for the purpose of characterizing the "normal situation". It may also be that family members will have a different evaluation, possibly something between patients and a control sample, and this would in itself be an interesting research finding. In any case the task would be to try to find out what norms are prevalent by aggregating from the distributions of the respondents, using not only averages but also other measures of central tendency and controlling for the level of dispersion (being sceptical about the averages unless the dispersion is not too high).

For a social scientist it might be useful to look at key institutions, such as the places most people work, and how family life is organized, perhaps also something on associations to see how they are organized structurally. Various rates of "social disorganization" (criminality, alcoholism, etc.) may also be useful, though it is not quite clear what they indicate. The social scientist might also look at themes in children's books in the area, following the approach that was made very popular some years ago by D. McClelland (The Achieving Society). However, it is hardly to be expected that data of this kind will have the same level of sensitivity when it comes to reflecting prevalent norms as averages derived from the control samples.

The virtues of random sampling in social sciences have probably been exaggerated, among other reasons because there are so many other sources of errors in social science methods in general that extreme caution against sampling errors may be somewhat misplaced relative to these other factors. On the other hand there is no doubt that the situation of the mentally ill has to be evaluated relative to the "normal" situation - which immediately would lead one in the direction of trying to proceed by the method of matching. One procedure suggested,

to make use of people who come to clinics anyhow but as "normal" people as possible - e.g., people who have been exposed to accidents - is probably the best one possible, although it would be entirely compatible with the history of methodology of social sciences if later on it is found that these people are accident-prone, thus introducing a systematic bias.

The only thing one should warn against would be to conceive of the other sample as necessarily "normal". It is simply a control sample, and how it differs will emerge clearly when one looks at all the structural and attitudinal variables, and it is on this basis that conclusions will have to be drawn. To assume that they are "normal" would be to assume too much, for instance that the general socio-cultural conditions are such as to produce health in all but a few cases.

Of particular importance is the conceptualization of family functioning with regard to its relations to the presence or absence of a mentally ill member of the family. One approach would probably be to draw up a list of functions that the family is performing or the family members are performing at least to a large extent together, and see to what extent the mentally ill is present or absent in those activities. Similar procedures can be used in connection with a study of very old or very young members of the family: when are they permitted to participate? (examples: their own birthdays, other family members' birthdays, holidays, funerals, particularly difficult situations or particularly festive occasions, etc.). The degree of behavioural integration would be important, and it would also be important to know to what extent the mentally ill member of the family is participating as a real participant, or merely as an observer, a spectator to the activities. Also important would be to know what kind of attitudes surround him, particularly where the family members draw the line, feeling that beyond that line no further participation or integration is possible.

One dimension that could be used here would be the distinction between production and consumption functions of the family. As most Western societies today have produced family systems that are essentially communities for consumption, not for production, the list is already limited beforehand - what the family members do when they exclude the mentally ill is only to complete an already ongoing process. Hence it would be important not to take as baseline the list of common activities that is "normal" in the community, but to operate from much richer assumptions than that. In general, for instance, one might even assume that productive collective activities are more integrative because of the injection of elements of personal initiative, even creativity, than collective consumption.

In addition to this, however, one should also have some information about the family itself - not only how it reacts to the mentally ill member. In doing so I would then recommend utilization of the same variables as have been recommended for the study in general: division of labour, penetration, fragmentation, segmentation, marginalization. In other words, to what extent are tasks in general shared relatively evenly in the family, to what extent is the task specialization with parents in general and the father in particular monopolizing all opportunities for creativity, to what extent are family members doing their own thing, to what extent is one group of the family isolated from the others (e.g., according to generation or sex lives). It would be interesting to have a judgment on this not only from the key informant in the family, but also from the patient himself or herself - including some estimates of the degree of "emotional warmth" in the family. In short, how do they see their own family, how do they define it?

Combining these sets of information, subjective and more objective, at the macro and micro levels, one should be in a position to locate the mentally disordered as well as the mentally healthy in the control sample in the cells of Table 2. And that is the purpose of the methodological exercise, as related to the theory section above - however limited it is to structural-cultural factors.¹⁶⁾

NOTES

*The present paper is an outcome of a "contractual service" with the World Health Organization, Geneva, spring 1976, defined in a letter of understanding of 15 December 1975. I am grateful to Dr. Assen Jablensky of the WHO Division of Mental Health for many inspiring discussions of this theme, but the responsibility for the conclusions is my own. Written in 1976 (with a little revision and updating) I would like to apologize for the male language used, "man" and "mankind" etc. where today I would have said humans, humankind. The ideas contained here will be developed further in a special study group under the Goals, Processes and Indicators of Development Project.

(1) The International Pilot Study of Schizophrenia, IPSS, was the project giving rise to the present small study, essentially an exercise in epistemology. For some information from the early phase of the project, see Sartorius et al., "Preliminary Communication, WHO International Pilot Study of Schizophrenia", Psychological Medicine, 1972, pp. 422-425; the editorial "Culture and Schizophrenia" in Psychological Medicine, 1975 pp.113-124; the two volumes Report of The International Pilot Study of Schizophrenia, WHO, Geneva 1973 and 1979, and, important in this connection, the article by Sartorius, Jablensky and Shapiro, "Preliminary Communication, Two Years Follow-up of Patients Included in the WHO International Pilot Study of Schizophrenia", Psychological Medicine, 1977, pp. 529-541. The five years follow-up as well as the general conclusions of the IPSS will be published by WHO in 1982. I think the general findings from the IPSS, as relevant to the present study can be summarized by quoting from the summary of the 1977 particular article:

"Over 90% of the 1202 patients investigated in the 9 countries collaborating in the IPSS were traced two years after the initial examination and, on the average, over 75% of them were re-examined using standard instruments and methods. - - Schizophrenia patients in the centres in developing countries /Agra, Cali and Ibadan/ had on the average considerably better course and outcome than schizophrenic patients in the centres in developed countries /Aarhus, London, Moscow, Prague and Washington - Taipei was excluded as not easily classifiable/. Part of the variation of course and outcome was related to sociodemographic (eg social isolation, marital status) and clinical (eg. type of onset, precipitating factors) predictors but another larger part remained statistically unexplained". (p.540).

(2) Intuitively one might say it would help for the healer to have some of the same ill-health as the patient; it would be a factor of empathy. To have given birth should be valuable to a gynecologist, so the high number of men in this branch of medicine can only be explained in terms of male dominance, including the right to define such experience as less important. Is the same the case for mental disorder? Can the mentally healthy really understand the mentally ill, and will the latter not experience the former as aloof, detached, cold, remote? Would it be possible to think in terms of a "healer" who could quickly go through a healthy-ill-healthy cycle and so to speak join the ill person where he is and bring him with himself back to health? It is something like this the shaman, is doing, obviously a person less compulsively normal than the psychiatrist of our societies?

A more positive view of schizophrenia, somewhat in this direction, is reported in an article "schizophrenia is Linked to Social Evolution", International Herald Tribune, 12 December 1975, p.3, according to which Dr. E. Foulks of the University of Pennsylvania maintains that "schizophrenia is a mental condition that is found worldwide - - because it provided certain evolutionary advantages. Schizophrenics may have helped effect social change when traditional methods failes - - /schizophrenics/ adopted the role of prophet or shaman, to help the society cope with its stresses". (italics ours). There may be something to an interpretation of this kind, but it should be emphasized that such views tend to take "social change" for granted and then look for patterns of human adaptation, instead of taking human beings for granted, looking for patterns of adaptation of human society to patterns of human needs.

(3) This is a key finding of the IPSS, as mentioned in footnote 1 above. The full quote is (ibid., p.536): "Three socio-demographic predictors appeared consistently among the best predictors of this class: social isolation, associated with a poor outcome; marital status - widowed, divorced or separated, associated with a poor outcome; and marital status - married, associated with a good outcome".

(4) For much more details on this, see Johan Galtung, "On Alpha, Beta and Their Many Combinations" in Masini, Galtung (eds.), Visions of Desirable Societies, London, Pergamon, 1981 (Spanish version CEESTEM, Mexico, 1979, pp.19-95. For a shorter version see the first chapter of Johan Galtung, Development, Environment and Technology, UNCTAD, Geneva 1979.

(5) Of course, there are some important arguments in favor of the process hypotheses - only that they do not exclude the validity of the other hypotheses - that the Alpha strong/Beta weak combination is a dangerous one. Thus, in the passage from "traditional" to "modern" there will be many people with disequibrated rank profiles (see, for instance, the section on this subject in Johan Galtung, Peace and Social Structure, Essays in Peace Research, Vol.III, pp. 105-196); and there will be much incongruency between traditional and modern structures that will confuse, disorient many people. However, if the rate of change

were decisive, then one would expect the rates of mental disorder to taper off as a "modern" configuration is reached, unless one assumes that change simply continues all the time. In that case the concept of change may be almost identical with the concept of "modern" society, and for that reason the hypothesis would become close to a tautology.

For an example from the "third world", see The Straits Times (Singapore) Sunday July 9, 1978 where it is pointed out that the attendance for psychiatric treatment at outpatient clinics in Singapore increased from 28.138 in 1973 to 62.214 in 1977; a rise of 121% in only three years. Hospital admissions for mental illness rose by 56% from 2.707 in 1973 to 4.229 in 1977 - indicating the usual tendency towards outpatient handling of the phenomenon. Time will show what kind of trend this is - it certainly looks strong.

(6) The "strong alpha/weak beta" hypothesis is, of course, compatible with the findings quoted in footnote 1 from the IPSS: alpha is stronger in developed than in developing countries, beta weakness plays a role in both of them and social isolation and marital status as widowed, divorced or separated as negative predictors of mental health (op.cit. p.536) are clear examples of weak beta. It should be noted that the prevalence of schizophrenia may not vary much, as opposed to course and outcome. Even if the prevalence should be roughly speaking the same, the prognosis may be much better for patients in developing countries, with shorter episodes of symptomatology, a smaller number of relapses, less social disability. From the point of view of the patient that certainly matters and also serves as a warning that the mere statistics of numbers of incidence and prevalence are insufficient; they do not reflect the quality, only the quantity of "severe and chronic incapacitating psychotic or dementing disorders" - "in most countries approximately one per cent of the population - - while another 10 per cent have non-psychotic mental disorders" (from a note on "Mental disorders", by Dr Assen Jablensky).

The general mental disorder situation in European countries, according to a WHO study from 1969-72 is described in terms of the 20% of the population who have sought, or during their lives will seek psychiatric assistance in one way or the other (Dagbladet, Oslo, 9 December 1977). Odd Steffen Dalgard reports (Aftenposten, 18 May 1977) the figure of 15% for Oslo inhabitants 20 years old and above. Stress symptoms such as depressions, sleeplessness, tension are reported more frequently by women than by men. The tendency to seek psychiatric assistance varies very much with the environment: in a satellite town it was 20% (11% during the last five years alone); in older parts of the city only 4-5% and in more well-to-do districts only 2% - but then only 1% of the inhabitants in such districts felt these were bad places for children to grow up as against 40% for the satellite towns.

Another study by Odd Steffen Dalgard is also very interesting in this connection ("Occupational Experience and Mental Health, With Special Reference to Closeness of Supervision", Psychiatry and Social Science, Vol. 1, No. 1, 1981). There is "a rather strong statistical association between occupational experience

and mental health. 'Closeness of supervision' at work stands out as one of the most powerful variables. By increasing the degree of perceived 'closeness supervision', the frequency of mental health problems is increasing, no matter if the indicator used is contact with psychiatrist or psychiatric symptoms as elicited by the interview. - The most likely explanation is that strong outer control in the job situation is felt as something stressful, by frustrating basic psychological needs, and hence contributes to mental health problems. - - people who expect things to happen as a consequence of own initiative and effort show a particular strong tendency towards mental health problems by increasing closeness of supervision".

(6a) As will be pointed out later I see the idea of sorting, the pure from the impure, as essential in Western civilization. Bacteria and virus have offered a sickness theory that makes it possible to sort the cause away from the victim, isolating the cause, and destroy it. Not so with the insane and the criminal - they themselves had to be isolated, and the rationale for this had to be found. Michel Foucault's incredible Madness & Civilization, A History of Insanity and the Age of Reason (originally in French as Histoire de la folie, 1961), Random House, New York, 1965 is a potpourri over this theme. In a dramatic passage of the book Foucault pinpoints the issue (p. 242):

"He asked to interrogate all the patients. From most, he received only insults and obscene apostrophes. It was useless to prolong the interview. Turning to Pinel: "Now, citizen, are you mad yourself to seek to unchain such beasts?" Pinel replied calmly: "Citizen, I am convinced that these madmen are so intractable only because they have been deprived of air and liberty".

Of course, this is too simplistic, as it is simplistic to see the psychiatric hospital only in "alpha strong/beta weak" terms, leaving the inmates with no alternatives but building their own small beta structures (as they did in the movie "One Flew Over the Cuckoo's Nest"). But that the perspective has some validity is born out by numerous studies.

For material on this see eg. John Wing and George Brown, Institutionalism and Schizophrenia, 1970. Chronically schizophrenic women in three hospitals were interviewed and the social atmosphere of the hospitals were analyzed along dimensions quite similar to the alpha-beta distinction made in the present paper. Lack of contact seemed to be a key negative factor (the marginalization-fragmentation-segmentation syndrome); leading to apathy/inactivity and the production of symptoms of disorder. Medication did not seem to help much whereas changes in the atmosphere of the hospital gave results.

(7) One interesting, non-trivial consequence of the alpha-beta hypothesis would be that the mental health situation in rural areas under industrial agriculture should be even worse than in the big cities. Both of them, in "modern" countries, would be heavily alpha-directed by the logic of the economic and political systems. But the big cities should offer much more beta opportunity than a countryside if the latter is mainly

constituted by scattered farms, with little in terms of villages or originally alive small towns. This kind of thinking is born out, to some extent, by the judgement of Dr Leo Srole who was director of the famous Midtown Manhattan Study "which in 1962 produced a landmark report on the psychiatric health of New York City. The report, based on interviews with 1.660 residents of Manhattan's East Side, rich and poor, found that 23 percent of those interviewed were in need of psychiatric treatment". Then, he continues:

"Dr Srole called the anti-urban bias of many social commentators and politicians an 'undocumented indictment'. On the basis of new evidence uncovered in the continuing study, Dr Srole is now asserting that, however sick the city appeared to be then, it now appears that small towns and rural areas are even sicker. (*italics ours*) --- the big city may be a healthier accommodation to the human condition than the small town".

This is also born out by a National Center for Health Statistics study on 6.700 persons in 1962 where "those who lived in rural areas and in cities with populations of fewer than 50.000 had symptom scores that were nearly 20 percent higher than those than those who lived in cities of more than 50.000". And there is the "comparison of the mid-town Manhattan data with a similar survey made by Leighton in rural Stirling County in Nova Scotia. In Stirling County, people live at an average density of 20 per square mile; in Manhattan the density is 75.000. - - Stirling's estimated mental morbidity rate is higher than midtown's by a wide and highly significant statistical margin". All of which goes to show that the fruitful independent variable is not the urban-rural dichotomy, but something more complex like the alpha/beta dialectic. According to the latter both urban and rural settings can offer high levels of mental health provided alpha is not too strong and beta not too weak, and both of them may produce poor mental health with the opposite configuration.

Imagine now that a highly disintegrated big city "pulls itself together" in the sense that people start developing various mechanisms of defense, more collective life, more mutual aid, more ethnic togetherness, maybe precisely because they feel threatened. This should strengthen the beta component. If anything like that happened in Manhattan in the early 1970s it would be highly compatible with Srole's finding, comparing the respondents rating in the original survey with the ratings he obtained when managing to reinterview 695 of the 1660 original persons in 1974 - 20 years after the first interviews. Comparing the "mental health ratings of those in their 40s now with those who were in their 40s 20 years ago /he/ found that the proportion in need of psychiatric help had dropped by half. A similar decline was measured in comparing the generations in their 50s now and 20 years ago". Again an indication, however interpreted, that the urban-rural dichotomy may be insufficient (all quotes from "Mental Health of Big City Dwellers Receives Boost from Sociologist", International Herald Tribune, May 7-8 1977).

There are, however, many other hypotheses in this field. Following a discussion by the Norwegian specialist Nils Johan Lavik ("Industrisamfunn og psykisk helse", Dagbladet, 2.august 1977) the selection hypothesis (that people who are vulnerable or predisposed genetically or otherwise might tend towards cities); the resource hypothesis (that people with low class position simply have fewer resources to cope with the situation); the family hypothesis (that people with broken family are more vulnerable) and the ecological hypothesis incorporating psychophysiological, sensorial and genetical factors (eg. the incidence of lead in the atmosphere, as discussed by Bryce-Smith and Walderon in The Ecologist, 1974, No.4) and the density of the population (some density makes the possibility of creating beta communities, more density may create apathy or other forms of breakdown). In a sense all of these four approaches are spelling out mechanisms of the general alpha/beta dialectic. There is no denial that alpha attracts. The question is what alpha does to people, both those uprooted and those who were there to start with. That those at the bottom of alpha without beta protection have little in terms of social resources to draw upon is obvious - but the hypothesis also, rightly, brings in other recourses. That beta destruction implies family destruction is a tautology. And as to the various ecological hypotheses: alpha pollutes, but non-polluting alpha may also have the same effect in terms of producing mental disorder for purely structural reasons. At any rate, the research is now a far way from the pioneering study by Faris and Dunham; for a survey see "De l'écologie à l'étude des communautés", in Roger Bastide's Sociologie des maladies mentales, Paris, Flammarion, 1965.

(8) For more details on this, see the first chapter in Johan Galtung, Development, Environment and Technology, UNCTAD, Geneva, 1979.

(9) Thus, one important question is whether it will hit high or low social positions, or both equally - the latter being unlikely. The subjective frustration might be most keenly felt high up in society as their projet crumbles; the objective frustration more in the lower positions as those high up will try to deflect the pressure downwards through abolition of social welfare practices, etc.

(10) It is enough to mention again the brilliant studies by Michel Foucault, such as The Birth of Clinical Medicine, Surveiller et punir, Madness & Civilization.

(11) See Johan Galtung, "Institutionalized Conflict Resolutions", Essays in Peace Research, Vol. III, Peace and Social Structure, Copenhagen 1978, pp. 434-483.

(12) Also a theme from Foucault's prolific work!

(13) This is developed in Johan Galtung, Theory and Methods of Social Research, Allen & Unwin, London 1967, pp. 103 ff.

(14) The book by that title was published by Mouton, The Hague, in 1976, with Ornauer, Sicinski, Wiberg and Galtung as editors (729 pages).

(15) The following quote from the conclusion gives some of the general tenor of the findings (p. 118):

"-- these are not data reflecting an innovative humanity exploring and facing a fascinating open-ended future. These seem rather to be data reflecting a humanity with its back to the future, looking at the past, and the present - and projecting from that experience into the future. In a sense these are the data one would expect at the end of a phase in human history, not at the beginning of a new one".

(16) As an example of biological factor thinking, see the study by Ralph Bolton, Aggression and Hypoglycemia in Quolla Society, Garland, New York 1976, where the hypothesis is pursued that low blood sugar (hypoglycemia) will enhance individual aggressive tendencies and thus become a determinant of anti-social behavior in interpersonal conflict.

For another interesting effort based very much on psychological factors see Lennart Levi, "Situations stressantes, reactions de stress et maladies" in the Symposium Medical International: "Stress, Maladies de la Civilisation et Vieillesse", Laboratoires Robert et Carriere, Paris 28-29 April 1975, pp. 26-36.