Symptoms of Mental Disorder in the Philippines

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An initial and crucial step in the development of any science, pure or applied, is a detailed understanding of the phenomena with which the discipline must deal. At present there are too few systematic studies of the symptoms by mental patients in the Philippines. While there might be some objections to the need for such studies on the ground that sufficient investigations have already been accomplished in other countries, the need for studies carried out in the Philippines cannot legitimately be questioned (Varias, 1963). There is a growing body of evidence that mental disorders show a differential frequency of occurrence from one culture to another and that the form, i.e., the symptoms, the disorder takes is profoundly influenced by the culture in which the patient resides (Opler, 1956). There are, for example, two broadly general but competing hypotheses about the relationship which exists between culture and symptomatology of mental disorder. One hypothesis, which I choose to call the *cultural deprivation* hypothesis, is that symptoms of mental disorder will reflect the restrictions on action current in a culture, i.e., that there will be something of an inverse relation between tendencies strong in a culture and symptoms which occur. An instance of the kind of observation which suggests such a conclusion is the finding of an unusually high incidence of manic-depressive disturbance in India, a country which presumably provides ample opportunity for rumination and withdrawal and therefore does not provoke schizophrenic tendencies (Dhunjobhoy, 1930). The second hypothesis, *cultural facilitation*, is that symptoms of mental disorder will consist of exaggerated forms of those behaviors which are prevalent and encouraged in a culture. An instance of research finding consistent with such a hypothesis is the finding that in a mental hospital in Hawaii patients of Japanese descent have a strong tendency toward symptoms of withdrawal, while patients of Filipino descent show more hostile aggression (Hawaii State Hospital, 1961). The present paper, is then, written with an eye both toward the development of correct normative expectations about various symptoms and symptom patterns in the Philippines and toward the possible relationship between Filipino culture and mental disorder.

The data to be reported are only a portion of a larger investigation into the nature and incidence of mental disorder in the Philippines, attitudes toward mental disorder among Filipinos, and the management of cases of mental disorder at both the lay and the professional level. It must be acknowledged that this is a preliminary report. However, it is believed that the data now available are strongly suggestive of final conclusions and that the confidence in these preliminary data is justified and augmented by the findings of previous investigators.

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THE IMPORTANCE OF SYMPTOMS

One would not wish to be supposed quite so navie as to believe that symptoms constitute the whole of mental disorder, for certainly the problem of a behavioral disturbance has many more ramifications than are explicit in an account of the specific behaviors which are awry. Nonetheless, the writer is quite convinced that symptoms are important, if not exclusively so. There seem to be two general justifications for the importance of symptoms. First, the symptoms of a mental disorder are the complaints which are made, the problems which lead to the initial diagnosis of "something wrong." It is quite correct to say that the initial diagnosis of mental disorder, or at least of "something wrong" is always made by someone other than a psychiatrist or even a physician. In fact, the first diagnosis is almost always made either by the patient himself, or by a member of his family. The symptoms are what lead to the conclusion that something is wrong and result in the patient being brought in for treatment or otherwise coming to the attention of authorities. They are the problem to be dealt with. People complain of symptoms, not of "causes," "dynamics," or something of that sort.

It also follows, then, that the symptoms which are displayed are what determine (a) whether anything is recognized as being wrong, (b) whether anything is done about it, and (c) what is done. At the National Mental Hospital, Mandaluyong, Rizal, the writer has found rather marked "admission gradients" for geographic locations. For example, the closer an area is to Mandaluyong, the greater the number of patients from that area who will be in the NMH. As one goes any appreciable distance from the hospital, the number of cases in the hospital from that area decreases *markedly.* Apparently the symptoms which lead to hospitalization in Manila turn out to be tolerable in more remote places. Moreover, the gradient is especially marked for women. At NHM women and men are admitted in approximately equal numbers from Manila and the immediately surrounding areas, but as one goes as far away as Nueva Ecija or even Batangas, one begins to find a preponderance of male admissions. Apparently the symptoms of females are particularly tolerable. We must, then, study and come to understand the symptoms which are presented as complaints and which lead to decisions about the management of patients.

A second importance of symptoms is as behavioral indicators of the condition from which the patient suffers. Although symptoms are not the only basis for the diagnosis in clinical psychology and psychiatry, their importance is obvious. And in some instances, they are literally all the clinician has to go on, at least in the early stages of the investigation, e.g., when a patient is brought in off the street by policemen to whom he is a stranger.

PROBLEMS IN STUDYING SYMPTOMS

There are a number of problems likely to be met by any investigator who attempts to study symptoms. All the problems to be mentioned were encountered in the present investigations and, sad to say, few of them were finally solved.

Rather obviously if one wishes to study symptoms one should have available informed, even specially and highly trained, observers. Certainly not just anyone is qualified to examine a patient or even to observe him and report the symptoms he displays.

Unfortunately, informed observers are difficult to find, particularly if one chooses to study patients outside some clinical setting. On the other hand, even uninformed observers can tell what they notice about the patient or why he was brought in for treatment. Thus, even if we would not consider the uneducated, perhaps even ignorant, mother of a patient a very well informed observer from the standpoint of elaborating the subtle symptoms that are often of critical importance, that mother can still tell why she brought the patient in, i.e., what symptoms she observed. In the data reported below for "barrio" cases, it cannot be maintained that the informants were all particularly well informed. However, it is the omission of symptoms, not the inclusion of erroneous ones. Thus the reports are to be regarded as consisting of the more obvious symptoms.

There is a second problem that arises because observers, even if well trained, may be biased in either the observations they make or their reports. For example, some observers with a marked theoretical orientation may have such expectations about what symptoms *ought* to be found that they suffer a decrement in reliability of either observation or reporting. A typical example would be of the expectation that patients showing other "schizophrenic" type symptoms would also show "flattered effect." Other informants may be biased because they are in some manner involved with the patient, e.g., a relative, and thus be either biased in the observations which they make or in the reports which they give. Very likely the reports given by relatives bringing patients in for treatment are only partially trustworthy because of an over reporting of "acceptable" symptoms such as somatic complaints and an underreporting of less acceptable symptoms. On the other hand, it is not to be supposed that the biases of relatives will always be in the direction of underestimating the seriousness or even the degree of deviation of a patient's condition. It has been called to the writer's attention that at the very crowded National Mental Hospital where a patient's case must be very serious in order to merit admission, relatives may be led to exaggerate reports of violent, destructive behaviors in an attempt to gain admission of the patient to the hospital.

In order fully to understand a patient's condition in terms of the symptoms he displays one should also know how characteristic the symptoms are of that particular patient. For example, it will be seen below that a fair number of patients are noted to be or to have been mute or unresponsive. However, a fairly sizeable proportion of the same patients were also reported to be over talkative, noisy, etc. It is the writer's clear impression that very few of the patients were characteristically mute or unresponsive, but often the bare accounting of symptoms made it difficult to tell. Moreover, symptoms will differ in their salience and thus in the probability of their being reported. Violence, for example, has a very high probability of being reported. It is noticeable, even demanding of attention. On the other hand, many delusional ideas, perhaps even hallucinations, are much less salient and less likely to be reported.

Still another problem, perhaps one that is particularly apparent in the present study, is that many of the most interesting symptoms are relatively rare, and that if one does not have a sample of rather large size, such interesting symptoms will be missed together.

Finally, since the present investigation purports to have some orientation toward cross-cultural comparison, there is an evident need for comparability in cross-cultural

samples. The investigator confesses that comparability of samples will prove to be a very diffident standard to meet for some comparisons which might be desirable. For example, the present Filipino sample would be rather difficult to match in the U.S. in terms of educational status and occupational status, not to mention a multitude of other important variables. For that reason, conclusions which are drawn can be only tentative, advanced with apologies, but with heuristic zeal.

CULTURAL BIAS IN DEFINITION OF MENTAL DISORDER

It is evident that what constitutes mental disorder is a question with a very strong cultural bias nearly built in. Unfortunately, it is not even especially clear what considerations are involved in deciding whether a given get of behaviors constitutes a mental disorder, only a permissible behavior deviation, or a moral transgression. Such differences will affect not only the overall incidence estimates for mental disorder, but those which are brought to the attention of authorities and, therefore, ever studied. A good example of biases current in psychiatry today is contained in the two brief tales which follow:

S. A student in a university receives a low grade from one of his instructors, and when he tells his parents about it, they scold him for his poor performance. The student then admits that he did not work hard enough and confesses that he may be too dumb to get through the university anyway. As he thinks about it, he feels worse and worse, and later that evening he shoots himself.

M. A student in a university receives a low grade from one of his instructors, and when he tells his parents about it, they scold him for his poor performance. The student becomes angry and tells how unfair the instructor is. In fact, he is pretty sure that the instructor has it in for him. The more he thinks about it, the angrier he gets and later that evening he shoots the instructor.

Probably almost all workers in mental health fields would immediately recognize S as a pretty clear-cut case of mental disorder. Suicide, at least by a physical healthy individual, would be regarded as *prima facie* evidence of mental disorder. However, there would be, and I have verified this, a greater reluctance to consider the second case, *M*, as involving mental disorder. It would certainly be regarded as unfortunate, probably as a moral transgression, but not as certainly indicative of mental disorder as suicide. However, suicide seems to be the Japanese pattern. The second pattern is probably more nearly a Filipino pattern. Which culture, then, has a higher rate of mental disorder?

Or, to take but one more example, consider the widespread beliefs in witchcraft, sorcery, and similar phenomena in the Philippines. Were those beliefs encountered in the United States, they would almost certainly be considered indicative of some degree of mental disturbance. Of course, it can be argued that such beliefs are culturally conditioned and thus to be expected in the Philippines with its long history of animism. To that argument there are two replies which the writer would make. First, the cultural conditioning of certain forms of behavior is exactly what is at issue. It is very difficult to say just what

constitutes a mental or behavioral aberration because of cultural biases. Second, there arises the question of which cultural standards to apply in a transitional society. At some point old cultural standards must give way to new ideas about aberrant behavior change. Ultimately beliefs in witches and sorcery will come to be considered quite deviant in the Philippines, and that time will be when education and other forms of cultural transmission have so completely broadcast new and more acceptable standards of belief and behavior that adherence to old forms must be regarded as personal rather than a cultural aberration. At the present time, one wonders whether belief in witchcraft and sorcery is not somewhat more prevalent in the Philippines than would be expected from knowledge of the educational system. Finally, the writer would point out that beliefs in witchcraft and sorcery are not trivial, insignificant beliefs. People act on them in ways that indicate their central importance. Killings of "witches," for example, are reported every few weeks, and there are places where sorcerers are regularly consulted (Lieban, 1960).

CHARACTERISTICS OF THE PRESENT DATA

The data to be reported consist of three basically different types of cases coming from multiple sources. First, some of the data consist of reports on patients being treated in an institutional setting (in-patients). Cases were obtained from files, both active and inactive, of the National Mental Hospital and of the Philippine General Hospital's Psychiatric Section. While the investigator would not care to defend the thesis that the cases were selected on a strictly random basis, an attempt was made to avoid any systematic bias in picking cases, and the investigator believes that internal checks on the consistency of the findings justifies the belief that the cases chosen are representative. The second category of cases are those being treated as out-patients at a number of different hospitals and clinics. Since at this time the number of cases is small, the data are to be considered tentative, but the results will be seen to be congruent with findings on the out-patients and with expectations about differences between the two groups. Again an attempt was made to select cases in such an unsystematic manner that they would be representative of the entire population, but no genuine randomization procedures were used. The investigator would note that certain cases were excluded from the analysis, viz., children under the age of 14, cases diagnosed as "mental retardation," and cases diagnosed as "epilepsy." The third category of cases consists of those individuals identified as probable cases of mental disorder who are residing at home and who are not under active psychiatric treatment. These are labeled "Barrio cases" since most of them do live in barrio, as opposed to urban locations. These cases were "located" by the expedient of interviewing (a) teachers in public schools, (b) barrio officials (either captains or their vices), and (c) local practicing physicians. Where more than one person was interviewed from a particular community, an attempt was made to discover any cases described by both persons. In most cases that did not prove difficult to do. The reports of symptoms of barrio cases given in Table 1 are based on the reports of the persons interviewed. The cases were seldom known to the investigator.

The figures given in Tables 1 and 2 are for the proportion of cases showing a particular symptom. It should be noted that the symptoms are not mutually exclusive and that for

Table 1. Symptoms shown by three groups of mental cases in the Philippines

Symptom	SAMPLE In-Patients Male	In-Patients Female	Out-Patients Male	Out-Patients Female	Barrios Male	Barrios Female
Total N of Class	42	42	25	18	45	38
Impaired Sleep	.60[1]	.69	.48	.67	.13	.29
Impaired appearance	.12	.24	.12	.39	.08	.00
Impaired speech						
Excessive	.07	.12	.00	.11	.07	.05
Talk of self	.24	.24	.00	.11	.02	.16
Incoherent	.10	.12	.08	.33	.09	.13
Talk non-sense	.00	.00	.07	.00	.04	.18
Mute, uncommunicative	.21	.33	.00	.05	.09	.03
Singing, dancing, shouting	.26	.29	.04	.22	.32	.13
Hyperactive	.14	.10	.00	.00	.07	.07
Wander aimlessly	.26	.10	.08	.17	.20	.29
Hallucination-						
Auditory	.43	.33	.36	.22	.02	.05
Visual	.31	.14	.32	.33	.00	.00
Delusions						
Unpleasant	.57	.33	.60	.11	.02	.03
Pleasant	.14	.07	.00	.05	.04	.03
Ideas of feference	.12	.14	.00	.05	.04	.03
Irritable, Quarrelsome	.24	.36	.20	.28	.13	.16
Violent, dangerous	.50	.38	.32	.11	.27	.32
Destructive behavior	.24	.12	.04	.00	.13	.05
"Blank stare"	.21	.21	.08	.05	.02	.00
Unsociable seclusive	.19	.12	.16	.11	.02	.05
Withdrawn	.07	.07	.08	.11	.00	.00
Sad, depressed	.07	.21	.28	.17	.02	.05
Suicidal gesture	.12	.12	.12	.11	.02	.00
Somatic complaint	.36	.38	.56	.44	.00	.00
Somatic delusion	.05	.05	.08	.05	.02	.00
Phobic	.12	.05	.24	.05	.02	.03
Use of alcohol	.07	.00	.16	.00	.02	.00
Silly, bizarre, primitive behavior	.17	.24	.12	.11	.11	.11
Obscene, sex behavior	.02	.12	.08	.11	.00	.03
Religiosity	.17	.07	.00	.11	.00	.03
Avg N of symptoms per pt.	6.17	6.31	4.36	5.77	2.38	.263

this initial analysis no effort was made to weight the symptoms according to their importance. This means that, first, symptoms of a rather opposite nature, e.g., uncommunicative *vs.* excessive talk, were often recorded for the same patient. And it means, secondly, that the repeated instances of the same kind of behavior, e.g., repeated

Table 2. Content of Hallucinations and Delusions for Psychiatric In-Patients

Hallucinations	Male (N-125)	Female (N-145)
Content of Auditory		
Unspecified or innocuous	.58[1]	.42
Buzzing, ringing, knocking	.11	.01
Threats	.15	.19
Uncomplimentary	.10	.06
Complimentary, pleasant	.03	.08
Commands	.20	.28
Indecencies	.02	.00
Religious	.08	.19
Animals, Birds	.03	.10
Content of Visual		
Spirits, ghosts	.11	.11
Dead people	.08	.15
Devils, demons	.02	.07
Religious	.06	.17
Unspecified things, persons	.16	.14
Threatening visions	.02	.07
Bizarre	.04	.03
Fire, insects, animals	.04	.06
Living family member	.00	.02
Delusions		
Content		
Threats to kill, fear of killing	.26	.14
Other threats, enemies	.57	.57
Grandeur—wealth, fame	.12	.12
Grandeur—power	.10	.13
Other pleasant	.00	.08
Fear of poisoning	.07	.09
Somatic	.05	.04
Religious	.07	.22
Control of own behavior	.01	.00
Bizarre	.11	.09
Witchcraft	.01	.04
Punishment, guilt	.02	.04
Sex, jealousy	.14	.43
Thought diffusion	.02	.00
Thought control	.00	.01
Miscellaneous	.08	.19

[1]Figures indicate the proportion of cases showing the symptom.

episodes of violence, were recorded only once, i.e., as one symptom, for a given patient, and there is no way of knowing from the analysis at hand just which symptoms were most important or salient.

DEFINITION OF SPECIFIC SYMPTOMS

Some of the symptoms listed in Table 1 probably require a brief definition as follows:

Impaired appearance—any indication of lack of concern for ordinary standards of personal appearance and hygiene.

Wander aimlessly—any instance of wandering, roaming, or "going around" which took the individual outside his usual domicile.

Delusions, pleasant and unpleasant—all delusions were categorized in a straightforward way as involving probable pleasant, satisfying feelings or unpleasant, upsetting feelings.

Violent, dangerous—any physical or verbal threat to the welfare of other persons, including the possession of potentially dangerous weapons. (The investigator would note that verbal threats, usually to kill, were in nearly all instances associated with other behaviors such as carrying weapons or physical attack.)

Destructive behavior—refers to physical destruction of property, e.g., by arson, tearing apart.

Sad, depressed—includes all references to an individual *being* sad or *depressed* but not mere references to *looking* sad.

Suicidal gesture—actually includes all references to self-harmful behavior even if not of such magnitude as probably to threaten survival.

Somatic delusion—a belief about the anatomy or physiological functioning which is clearly untenable or bizarre from the standpoint of common consensus about the body, e.g., the belief that one's blood is turning to water, that one's insides are rotten, etc.

Phobic—any reference to persistent fears of an ordinary unjustified nature, e.g., fear of fire.

Use of alcohol—any mention of excessive use of alcohol.

Silly, bizarre, primitive behavior—any behavior that is suggestive of especially poor judgment about social acceptability, of a markedly deviant nature, or of a lower level of behavioral organization, e.g., self-decorative behavior, hoarding of useless objects, swallowing inedible substances.

Religiosity—any mention of religious preoccupation or excessive religious activity.

MALE-FEMALE DIFFERENCES

Even a casual inspection of Table 1 will show that within any of the three groups there are no very marked differences between male and female patients. In fact, statistical tests show that only one of the 96 differences is clearly significant, and that one difference could, of course, easily arise by chance. On the other hand, there are few of the findings which are consistent across all three groups, and later analyses, which must take into account the differing numbers of subjects in the various groups, might well show, some

consistent differences associated with sex. For example, females in all three groups show a higher frequency of impaired sleep, and males show a greater frequency of destructive behavior. Good examples of the problems in dealing with infrequent but interesting symptoms are provided by use of alcohol and obscene, sexy behavior. Apparently it would require a very substantial number of cases before any appreciable frequency of such symptoms would be encountered. Both give some indication of a sex bias that would be important and interesting. In fact, it seems clear that problems regarding the use of alcohol are likely to be almost completely restricted to males. Informal observations by the investigator, probably established at some time or other by research, indicate time or other by research, indicate that drinking by females is very infrequent outside the "sophisticated" segments of urban society.

IN-PATIENT-OUT-PATIENT DIFFERENCES

There appear to be only a few marked differences between the symptoms shown by patients being treated as in-patients and those being treated as out-patients. It will be seen that in-patients show a somewhat larger mean *number* of symptoms, a finding which could result from differences in diagnostic procedures but which is also consistent with the expectation that in-patients should be more seriously disturbed. Hunt, Wittson, and Hunt (1955) found that psychiatric judgments of degree of disturbance were highly correlated with the number of different symptoms displayed by a patient. Most of the differences between in-patients and out-patients are on some of the symptoms of a more serious disturbance, e.g., muteness, impaired appearance, unpleasant delusions, "blank star," etc., but there are one or two exceptions which may reflect differences in diagnostic procedures, e.g., the frequency of visual hallucinations among the out-patient groups. The relatively low frequency of violence among out-patients undoubtedly reflects a bias in admission policies.

THE MEANING OF THE BARRIO FINDINGS

The most noticeable feature of the findings from the barrio cases is the low mean number of symptoms reported. However, it must be remembered that the reports came from quite unsophisticated observers who could not be expected to be aware of many of the more subtle symptoms. Even with a sample of observers consisting mostly of physicians, Varias (1959) obtained a mean of only 2.33 symptoms per patient (writer's calculation). Moreover, while the cases reported by the barrio observers were all known to the observers, i.e., hearsay reports were excluded, they had usually not had extensive opportunities to observe the case, especially to the degree that would be necessary to know about somatic complaints, ideas of reference, impaired appetite and the like. Thus, there is a bias in the direction of reporting salient, publicly observable symptoms such as violence, shouting, wandering aimlessly, etc. It will be noted that some seemingly "private" symptoms such as impaired sleep are reported with some frequency, and silly, bizarre behaviors are reported with approximately the same frequency as they seem to occur in clinical populations. It is quite likely that most of the errors are of omission. It is not likely that symptoms are reported which are not displayed by the case in question, only that many symptoms are not reported.

IMPAIRMENT OF SLEEP AS A SYMPTOM

As will be seen from Table 1, impaired sleep is a very frequency symptom in the patients studied. Moreover, its frequency as a symptom is supported by interviews conducted by the investigator. Eight Filipino psychiatrists have been interviewed and asked to describe the common symptoms of patients seen by them, and six of the eight mentioned insomnia as the first symptom, the other two placing is second in the list. Mariano (1959) and Varias have also reported a high frequency of occurrence for insomnia among mental patients. Mariano studied 300 NMH in-patients and found impaired sleep in 73 percent of the cases. Varias investigated the knowledge a group of mental health workers consisting mostly of physicians had about mental cases and found insomnia reported in 17 percent of the cases. Neither figure is far from the comparable one reported in this paper.

It is also important to know that impairment of sleep is typically reported as a very early symptom. When informants, e.g., relatives are asked to recount the course of the patient's disturbance, sleep impairment is most always listed as one of the earliest symptoms noted. Obviously, then, impairment of sleep becomes of interest as a possible early diagnostic sign of mental disorder among Filipino patients. However, in spite of its frequency as an early reported symptom, it would be necessary to know the frequency of impaired sleep in the general population. If impaired sleep occurs with any appreciable frequency in general population, its usefulness as a diagnostic symptom is likely to be nil because of the large number of "false positive" cases (Meehl & Rosen, 1955). Or, to go beyond the minimum knowledge of frequency of the symptom in the general population, it would be of great interest to know the frequency of sleep impairment in other populations of persons undergoing stressful circumstances of some kind. It is quite conceivable that sleep impairment could be a valid sign of stress without being specific to the stress involved in psychiatric disorder. One would want to know the frequency of sleep impairment among such groups as acolyte lawyers about to take the bar exam, patients about to undergo surgery, and politicians anticipating election day.

It is unfortunate that exact cross-cultural data are not available to the investigator to substantiate his impression that sleep impairment is considerably more frequent among Filipino than among American patients. However, assuming for the moment that such is the case, an interesting problem is posed. Why? In order to answer the question we must keep in mind that the symptom is a complaint, i.e., it is based on the complaint of either the patient or a relative or both. It is not based upon objective determinations by a neutral observer. Is impairment of sleep actually more frequent or simply more likely to be complained about? Two hypotheses which seem to the investigator to merit investigation are that: (1) impairment of sleep is more noteworthy among Filipino, and (2) impairment of sleep is more likely to be noted among Filipinos. The first hypothesis would be true if undisturbed sleep is regarded as so "normal" that any departure from the pattern is remarkable. The second would be supported by a finding that perhaps because of limited space for sleeping quarters, impaired sleep is less likely to go unnoticed in the Filipino household.

VIOLENCE AND DESTRUCTIVENESS

One cannot help but be impressed with the frequency with which violence and destructiveness are mentioned as symptoms for Filipino mental patients. Moreover, irritability and quarrelsomeness are also very often mentioned features of mental disorder. It is almost certainly the case that violence, etc., is exactly what leads to hospitalization of patients in the Philippines. In fact, for one expanded sample of NHM cases, 62 percent of the males and 48 percent of the females were noted to be violent by the definition we have used. The percentages for destructive behavior were 18 for males and 16 for females. And the amount of overlap between reports of violence, irritability, and destructiveness is far from 100 percent so that a very sizeable proportion of cases would be characterized by one or the other of these symptoms. It is also of interest that in the vast majority of barrio cases who were not violent, it was specifically *noted* that they were not violent. (In one small sample of twelve cases for whom violence was not mentioned as a symptom, ten were specifically described as "harmless" or "not violent.") We are inclined to suppose, then, that Filipino mental patients are given to displays of violence or acting out of hostile impulses.

An obvious and demanding question is whether Filipino mental patients are more prone to violence than psychiatric cases anywhere else. Unfortunately, really good data are not available to the to the investigator to answer that question, but preliminary reports from Hawaii suggest that Filipino and Japanese mental patients in Hawaii differ in the direction of greater outward hostility on the part of the Filipinos and more withdrawal among the Japanese (Hawaii State Hospital, 1961). Considering for the moment the hypothesis advanced earlier that mental disorder will result in symptoms which are exaggerations of tendencies prevalent in the culture, the investigator would note that data available to him would indicate that Filipino culture is almost certainly characterized by a higher rate of outward violence than, say either Japanese or American culture. The frequency of murder in Manila as judged from newspaper accounts is almost certainly higher than in Chicago, and Chicago has three times the population of Manila. On the other hand, the suicide rate in Manila is *very* low, and what suicide there is, is accounted for by the Chinese population in disproportionate numbers. Thus, we would conclude that the frequency of violence among mental patients is simply an exaggeration of tendency prevalent in the culture.

Just why violence should be so much a problem in the Philippines is a question of considerable interest, but the writer would comment that the training of children seems oriented toward the denial or suppression of hostility, and yet there is an incompatible tendency toward arousal of hostility produced by the tendency to blame any misfortunes on other persons. Thus, if the writer's observations are correct, children are encouraged to blame others for their misfortunes, but they are proscribed from indicating their error in any open way. Therefore, feelings of anger go unlabelled, unrecognized, and ultimately uncontrolled. There are few, if any, intermediate expressions of anger taught to children, and when hostility occurs, it occurs in rather extreme forms.

INFREQUENT SYMPTOMS IN FILIPINO GROUPS

There are several kinds of symptoms or symptom patterns which seem to be quite infrequent in Filipinos, certainly less frequent than in comparable groups of American patients. First, it would seem that the withdrawal pattern is not characteristic of Filipinos who become mentally disturbed. At least upon first admission to treatment the usual catatonic symptoms appear to be infrequent if not absent. The writer encountered only one or two mentions of catatonic posturing among all the in-patients whose records were examined. Not a single case of catatonic stupor has been encountered, and even mute, uncommunicative behavior is not especially frequent. Most of the cases falling into the mute, unresponsive category are simply uncommunicative rather than mute, i.e., the patients refuses at some time to answer questions. Moreover, tendencies toward seclusiveness are not strong. Of course, it must be recognized that housing conditions in the Philippines would not permit many patients to seclude themselves physically. On the whole, however, it would appear that Filipino patients are more given to acting out of impulses, to outward display, as indicated by the rather high frequency of such behaviors as violence, destructiveness, irritability, shouting and singing, dancing, and the like. Just what the forces are in Filipino culture which would be conducive to outward display rather than to withdrawal is a matter for extensive study, but the writer would suggest that probably few observers would be likely to think of Filipinos as introverted, impassive, and unemotional.

A second symptom pattern which seems quite infrequent among Filipino patients is extreme "regression" culminating in such behaviors as urinary and bowel incontinence, eating or smearing of feces, public masturbation, swallowing of inedible objects, etc. Nor have other investigators reported an appreciable frequency of such symptoms (Mariano, 1959). In interviews with psychiatrists in various treatment installations, the investigator obtained estimates for the frequency of a "regressed" symptom pattern that appeared to center around ½–1/4 percent, even among psychotic patients. What the frequency would be in other nations remains to be seen, but the writer would hazard a guess that the U.S. figures would prove to be considerably higher. Whatever the conflicts of Filipinos, they probably do not center on the more primitive vegetative functions. Not once in all the cases examined has the investigator come upon a complaint of constipation. Whether constipation occurs or not is not known, but it doesn't seem to be complained about.

A third symptom pattern not occurring as frequently as one would expect is depression and guilt. Patients are frequently described as "sad" or "depressed" (more often as *looking* sad or depressed) but there is scarcely ever any elaboration on the description that would lead one to suppose that the patient really fits the psychiatric category of depression. For example, no instances were found of patients complaining of feelings of worthlessness, of hopelessness, of impending doom, and only two instances were found of complaints of being or feeling guilty. There were two or three patients who complained that they were being punished for something, but in no case did they indicate that the punishment were merited. The investigator would conclude, then, that depression is quite infrequent among Filipinos. A manic state is probably somewhat more difficult to distinguish

from various other diagnosis which might be used, but if there are manic episodes with any frequency among Filipino patients, they must be of brief duration and soon give way to the rather standard symptom pattern which is usually found. "Elated," "grandiose," "hyperactive," "perpetual motion," and similar terms often applied to manic patients were very seldom used to describe Filipino patients, either by their relatives or by the psychiatrists who interviewed them in institutions. Although there was a report of some years back suggesting that manic-depressive psychosis occurs among Filipinos with about the same frequency as among Americans in relations to schizophrenia, i.e., about a manic-depressive for every schizophrenic, that would no longer seem to be true (Kraph, 1950). Investigations by the writer revealed that the manic-depressive diagnosis was once fairly common at the National Mental Hospital; in fact, up to about 1934 or 1935 many patients were "diagnosed" simply as "mania." However, for the year 1962, discharges of first admission cases to the National Mental Hospital reveals a ratio of manic-depressives to schizophrenics (by the official diagnosis at least) of about 1:8 for women and 1:10 for men. Discharges of readmissions produced ratios of around 1:6 for both sexes. And even for those ratios it should be kept in mind that since manic-depressive supposedly have a more favorably prognosis than schizophrenics, they would be disproportionately represented among discharged cases. A survey of Municipal Health Officers conducted in about 1958 also found a ratio of manic-depressives to schizophrenics of about 1:10 (PMHA, n.d.). The investigator would, therefore, conclude that the actual frequency of manic and depressive reactions among Filipinos is rather low in comparison to Americans. That the low frequency is possibly rather specific to Filipinos among Asian groups is suggested by the findings of higher frequencies for Chinese and perhaps for Indians and Japanese (Lin, 1959).

If there is a low frequency of manic-depressive reaction in the Philippines, it needs explanation, but only tentative suggestions can be offered at this time. First, it has been noted that the manic-depressive reaction seems to show a socioeconomic bias in relation to schizophrenia with the latter diagnosis being more common among persons in the lower socioeconomic levels and certainly Filipino mental patients represented in the samples from the National Mental Hospital and other public institutions are overwhelmingly from the lower clases (Lin, 1953). The frequency of unemployment or underemployment is very high, and other indicators of economic or social status give a uniformly low estimate.

Carothers (1946) found a markedly low incidence of manic-depressive psychosis among Kenya Negroes, and he attributed it in part to the absence of an attitude of "self-responsibility" which he believes necessary for the development of a manic-depressive reaction. Whether such an attitude is lacking in the Philippines is a matter for research, but there have certainly been a number of observers, both native and foreign, who have commented on the tendency of Filipinos to deny personal responsibility for their actions and their lives. Moreover, another facet of the attitude of self-responsibility is the capacity for guilt, and guilt reactions are at least highly associated with depression if not necessary for it to occur. To the extent that the distinction between guilt and shame societies (Benedict, 1946) has any validity, Filipino society would seem to be more characterized by

the latter, e.g., the concepts of *amor propio* and *hiya*, often applied to Filipino behavior, are shame rather than guilt concepts.

Finally, it appears to the investigator that "neurotic" behaviors, particularly of the obsessive-compulsive variety, are relatively infrequent in Filipino groups. It is, of course, obvious that the samples described here would not be likely to include many neurotic patients. On the other hand, most psychotic patients usually show a rather surprising number of the milder, neurotic symptoms. Aside from a few phobic reactions, few neurotic behaviors were discovered and there definitely was not an instance of a compulsive or obsessive response. In support of the hypothesis that neurotic behaviors are likely to be infrequent among Filipinos is Kraph's (1950) observation that neurotic disorders are not common, and it will be noted that Varias (1959) reports no obsessive-compulsive cases among fifty seen at a suburban mental hygiene clinic. Lin (1953) found a very low incidence of obsessive-compulsive disorder among the Chinese and suggests that certain characteristics of the Chinese, culture may make obsessive-compulsive behavior unlikely. One such possibility suggested by LaBarre (1946) is that "sphincter morality" is poorly developed in the Chinese. Whatever sphincter morality is, it is probably not highly developed among Filipinos.

One further aspect of the relative lack of neuroticism among Filipinos is that addictive problems are, as yet, of little importance in the Philippines. Varias (1959) has commented on the low frequency of alcoholism, and the present data would bear him out. As can be seen, alcohol is not frequently mentioned even as a complicating factor in mental disorder. Moreover, narcotics addiction is also not an important problem in the Philippines, especially among those residents not of Chinese extraction. There may not be a sufficient underlay of neurotic anxiety to support addiction. Incidentally, that is not to say that alcohol is not a problem, for everyone knows that there is quite enough drunkenness in the Philippines. There are, however, apparently few persons in whom even habitual drunkenness develops into the craving and physiological dependence which we call alcoholism.

THE CONTENT OF HALLUCINATIONS

In addition to the cases already studied, records at the National Mental Hospital were searched for cases characterized by hallucinations and/or delusions. To the extent that it was possible the hallucinations and delusions were categorized according to content, and the results are given in Table 2.

As was apparent from Table 1, and as suggested by Samson (1963), hallucinations are most likely to be of an auditory nature. Very often the hallucinations proved to be of an amorphous, unspecified, or innocuous nature. In many instances about all that the psychiatric interviewer was able to elicit was that "voices" were heard. However, when content was elicited it is apparent that more patients experienced "commanding" hallucinations, i.e., commands or directions to perform some act, than any other kind. Religious content was rather frequent for women, and it will be noted that religious visual hallucinations and religious delusions are more common for women also. Finally, those hallucinations for which probable affect could be judged proved to be predominantly

unpleasant, being either threats or uncomplimentary remarks. Rather few patients appeared to experience voices making complimentary, laudatory remarks about them.

In the previously mentioned studies of Filipino and Japanese patients in a Hawaiian hospital, Filipinos were noted to have a lower incidence of auditory hallucinations than the Japanese, but those they had were likely to be of a threatening nature.

Visual hallucinations were also often not especially well specified in content, but it can clearly be seen that the bulk of them were unpleasant in nature. The investigator does not know what the frequency of hallucinations of spirits, ghosts, and dead persons is in other groups, but the frequency here seems noteworthy.

CONTENT OF DELUSIONS

Clearly, delusions held by Filipino patients are quite likely to be of a threatening, frightening nature. Delusions that one's life is actually in danger are common, and well over half the sample have delusions involving milder threats, including the belief that other people are speaking bad things about one. Delusions involving poisoning appear with some frequency and are very nearly the only type of delusion in which the manner of probable death is specified. One ore two patients expected to be boloed, and one thought he was going to be hanged.

It is very common among patients in American mental hospital to find patients who are fearful that someone is out to get them and even that they are to be killed. However, the "enemy" of the American patient is very often an abstract "they" or a large and impersonal body such as "the Communist Party," "the syndicate," or "the FBI." Filipino patients, on the other hand, almost always mention either family members or neighbors as those who intend to kill them. A few did name "the police" as their probable murderers, but it is clear that they meant the police known to them in their own towns and not some abstract entity remote from them. Perhaps the difference between the "enemies" of the Americans and the Filipinos indicates something about the pressures within the two societies, the American fighting to survive in an impersonal, large society that threatens to deny his existence, but satisfied in having no quarrel with his immediate neighbors; the Filipino little worried about society in general but preoccupied with the question of how to maintain smooth interpersonal relations with those persons living around him.

Although there are few differences between the males and females, two possible differences merit some mention. First, the "miscellaneous" category is larger for the females than for the males, and the excess consists almost entirely of beliefs which in effect represent denials of objective reality. For example, a number of women claimed either to be married when they were not or not to be married when they were. A few others claimed falsely to be employed in some job, that their husband was dead or similar things. Such beliefs were absent among the males. Whether beliefs of the nature described are properly to be called delusions is open to question, but in some instances they seemed firmly held and to be well elaborated. Why males don't have them is not known to the investigator.

Second, female patients have many more delusions involving sex and jealousy than do males. The delusions in that category for males consisted almost entirely of jealousy. Among females there were certainly many delusions of jealousy (and some might question how delusional many of them were), but females also showed a sizeable number of other delusions of a sexual nature, most of them consisting of the false claim to have a lover, usually someone prominent or even famous, e.g., President Macapagal, President Kennedy, the Mayor of Manila. A few women also claimed to be pregnant. No instance was encountered of a male who claimed to be the lover of a famous woman or, in fact, of anyone else. The males just did not show such delusions. Again, the explanation is not clear, but there is definitely the possibility that Filipino males are less conflicted about sex than females, and that sex has less personal meaning to them.

DELUSIONS WHICH ARE INFREQUENT AMONG FILIPINOS

There are three kinds of delusional patterns that appear to the investigator to be rare, much rarer than one would expect, in the Filipino population. First, only one instance was found of a Filipino male who heard voices or thought that other people were calling him homosexual. Such hallucinations and delusions are frequent in American patient groups. In fact, the Filipino group seemed generally low in sexual symptomatology in comparison to the frequent and well elaborated symptoms encountered in American patients. Unfortunately, very little information is available on sexual training and attitudes in the Philippines, and understanding of findings such as those in this paper will have to await further research. Certainly there does not seem to be a high level of concern about homosexuality in the Philippines, and the basis for strong conflict may be missing.

Second, delusions involving the belief that one's behavior is being controlled by other persons or is under their influence seem to be very infrequent. No cases were found in which an individual believed himself to be an agent of someone else, e.g., the Philippine Constabulary, or in which he believed that someone else was making him do things, e.g., controlling his movements by radio waves. Moreover, delusions of thought control were very nearly absent, and thought diffusion (belief that others are aware of one's thoughts, that they are being broadcast) was also very infrequent. All such delusions are almost certainly considerably more common in American patient groups. One possible explanation is based upon the very different attitudes toward independence in the two cultures. From birth Americans are taught to value and to strive toward independence is for them a potential source of conflict. In addition a high value is placed on privacy. Threats to independence and privacy would, then, be troublesome to the American. On the other hand, the Filipino pattern of child rearing and the prevalent cultural values place emphasis upon dependence and submission to the will of others. Privacy is not encouraged and valued. It might not bother the Filipino to feel himself influenced by others. It might not occur to him that it should be otherwise, and he would not feel sufficient conflict about such experiences to develop symptoms involving them.

Finally, delusions of guilt, nihilism, and death—all the delusions most nearly peculiar to depressed states—are rare or absent in this sample. These findings are consistent with the earlier contention that depression is rare among Filipinos.

A FILIPINO SYNDROME

One must ask whether there is a pattern of mental disorder that seems particularly to characterize Filipino patients. On the basis of investigations conducted to date the writer would suggest that there is a pattern of symptoms which seem very often to occur together in Filipino patients and which would represent something of a stereotype of the Filipino mental patient.

As a first approximation to the stereotype the writer would suggest the following: an individual begins to experience difficulty in sleeping and is noted very often to be awake at odd hours of the night and early morning; he is noted to be more irritable than usual and at times talks excessively; he is less sociable than before, and his efficiency at work or at household chores may suffer; at about this time he begins to complain that other people are talking about him and possibly that they have it in for him or even intend to do him harm; also during this middle stage of development the potential patient begins to become more and more restless and often takes to wondering around without any purpose, occasionally even to the extent of riding buses to neighboring municipalities; finally, the patient becomes loud, often shouting, sometimes sings loudly in public and even dances in the streets; he is often observed talking to himself and probably hears voices to which he responds; he is very easily irritated and tends to become violent when obstructed; he threatens people, stones them, hits them and is often searching for weapons. It is only at this point, unfortunately, that the family is likely to seek help from competent authorities.

The previous account is distilled not only from research data which have been reported here but from interviews with numerous psychiatrists, physicians, teachers, and ordinary individuals. Whether the picture given is an accurate one and whether it is helpful or not remains to be seen.

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