CONCEPTIONS AND MANAGEMENT OF MENTAL DISORDER IN SOME NEGROS ORIENTAL BARRIOS

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It is of considerable interest to know what is thought about mental disorder and how it is managed in communities far from professional psychiatric help, "far" being more a psychological than a spatial term. During the latter part of 1963 and the early part of 1964 the writer lived in Dumaguete City, a municipality of Negros Oriental, Philippines. As part of a larger investigation of mental disorder in the Philippines it was desirable that some information be obtained about mental disorder at the barrio level. It was not feasible to make community surveys of mental disorder, either from the standpoint of the time that would be required or from the standpoint of gaining the confidence of whole communities of people. Therefore, the decision was made to interview persons who would be in a good position to know about mental disorder in their own communities and who would be able to report reasonably well on aspects of the problem of interest to the investigator. School teachers were chosen as one class of informants since they reside in the barrios in which they teach and all the ones interviewed had been residents of their barrios for at least three years. Philippine barrios are ordinarily of small enough size that a teacher resident in the community for three years would know most families reasonably well. Moreover, because of their educational level teachers would be expected to be reasonably insightful and capable of good reporting. The other class of informants chosen was barrio officials, usually barrio lieutenants or former lieutenants. By the nature of their positions and duties barrio officials would know a great deal about their affairs. Moreover, barrio officials would be expected to be above average in intelligence and also capable of good reporting.

An opportunity to interview teachers arose when the provincial athletic contests were held in Dumaguete City, and all the various schools sent many of their teachers along with pupils. The teachers were solicited for interview during the time of their stay in Dumaguete City. The interviews were conducted in an informal manner by a Filipino college teacher[1] who made every effort to make the situation relaxed and comfortable, including buying refreshments for the teachers if they so desired. The interviewer described the purpose of the interviews as "scientific."

Interviews with barrio officials were, in nearly every instance conducted in the barrios, the interviewer having traveled to the barrios for that purpose. It was impossible to get a random sample of barrios, but no special criteria were exercised in selecting them. All were in the general vicinity of Dumaguete City, but interviews were conducted as far as 16 km. away. Again the interviews were conducted in an informal, and hopefully comfortable situation. No teachers and barrio officials were from the same communities.

The interviews followed a schedule as given in Appendix A, and all answers were recorded as nearly verbatim as possible. All the informants seemed friendly and quite willing to be interviewed. From all appearances they were frank in their statements, e.g., several of them described instances of mental disorder in their own families.

Some characteristics of the interviewees and their communities

Teachers. A total of 24 teachers was interviewed. Thirteen of them had lived all their lives in the barrio in which they were teaching, an additional five had lived in their barrios for 15 or more years, and the other six had lived in their barrios for from three to six years. Five of the 24 reported that they could not say how many families resided in their barrios, and the other 19 gave estimates ranging from 100 to 400 families. About half the barrios were said to have 200 or fewer families and about half 300 or 400. The teachers all came from barrios outside the municipality of Dumaguete and were from as far as 156 km. distance. Two were from Siquijor Island, offshore from Dumaguete by several km.

Barrio Officials. Ten barrio officials were interviewed in ten different barrios in and around Dumaguete. Eight of the ten were or had been barrio lieutenants, and of the three former lieutenants, two were currently serving as councilor and treasurer. One additional informant was barrio councilor and one was barrio vice-lieutenant. Eight of the ten officials were lifetime residents of their barrios, the other two having lived in their barrios for more than 30 years. The estimated size of the barrios was from 70 to 300 families with a mean of about 125 families, and the population of 1000. The barrio officials were, as might be expected, considerably more definite than the teachers in giving population estimates.

Number of cases reported

The 24 teachers reported a total of 28 cases involving males and 20 involving females, but four of the males were reported to be "cured," two were dead, and one had gone to live in a cave and had never been heard from again. One of the females was reported "cured" and two were dead. Thus, there were 19 current male cases and 17 female cases reported by the teachers. The barrio officials reported ten male cases of whom two were said to be "cured" and 15 female cases for a total of eight male and 15 female current cases. The proportions of male to female cases are not significantly different in the two groups. It should be noted that a number of the "current" cases reported by both barrio officials and teachers were said to be intermittent cases so that how many were actually in psychotic episodes at the time of the survey is difficult to say. The cases reported were widely disparate in age when age was reported, but the youngest reported case was of a 16 year old boy, and six were reported specifically (all by the barrio officials) to be over 60 years of age.

In general the greater numbers of cases were reported by persons residing in larger barrios, but the relationship would be of only modest size. The five barrio officials reporting the most cases reported a mean population of 200 families for their barrios. The five reporting the fewest cases reported a mean of 155 families. For those barrios for which teachers could give estimates of population the results were about the same, the four barrios with three or more cases having a mean population of about 225 families, and those six with no cases or only a single case having a mean population of 188 families.

Two barrio officials and three teachers reported knowing of cases which had been sent out of their communities for treatment, a total of nine cases being involved. Six of the nine had been sent to the National Mental Hospital where three were said to have expired and from which two were said to have been returned to the community as recovered.

Apparently mental disorder of a serious nature is not a great problem in these 34 Negros barrios. A figure of about one active case per 1000 population would be a reasonably close estimate of prevalence. Such an estimate might or might not be close to the "true" estimate, although it is consistent with other data (Sechrest 1964). In any case it is a reflection of the magnitude of the problem *as viewed by barrio residents.*

Symptoms reported

Symptoms reported for cases residing in barrios have already been reported in another paper (Sechrest 1963), but that report included cases other than those currently residing in their home communities. Hence, symptoms described for the present sample of current cases age given in Table 1.[2] No differences were noted in symptoms reported by barrio officials and teachers so their reports have been combined. Moreover, because of the small number of cases the reports on males and females have been combined. Remarkably little difference was noted in symptoms reported for males and females, even for

Table 1

Symptoms reported by interviewers for current cases of insanity in their barrios.

Symptom	*Number of cases having symptom*
Violent	16
Threatening	5
Harmful to own children	3
Destructive	6
Wander aimlessly	12
Commit social improprieties	12
Nuisance behavior	8
Quarrelsome	4
Senseless talk	10
Excessive speech	4
Talk to self	7
Sings without reason	3
Shouts	4
Laughs without reason	3
Peculiar, odd behavior	4
Stay away from home for long periods	3
Sleep or eating disturbance	2
Excessive drinking	2
Delusions, unpleasant	2
Delusions, pleasant or grandiose	5
Excessive jealousy	3
Childish	3
Withdrawn	1
Improper behavior with respect to opposite sex	1
Irresponsible	1
Excessive talking about women	1
Killed a cat by biting it	1

such behavior as manifestations of violence. For a number of cases no specific symptoms were described, but most informants gave at least one or two of the symptoms for the cases they reported on. It should be noted that the symptoms listed are those described by the informants as presumably justifying the conclusion that the individual was "insane." The symptoms might or might not be considered psychiatrically important although an examination of the list would suggest that nearly all of them would be regarded in much the same way by a psychiatrist as they are regarded in the community. In nearly all instances the symptoms were reported in terms of specific behavior, but they have here been categorized under more general rubrics. For example, the category "Nuisance behavior" includes such specific behavior as blocking traffic, entering homes without invitation, and carrying off property of other persons. No informant used the term "nuisance" as a description. Four categories were sometimes used without behavioral specification. Several informants said that the individual they were describing "became violent" without further indication of the meaning of violent. However, the category "violent" also includes cases showing such specific behavioral manifestations as "stoning people," "chased people with a bolo," "hit his father," and "wounded his wife with scissors." Also the term "childish" was used for three cases and the term "irresponsible" for one without any actual behavioral description.

The most obvious thing about the list of symptoms is that nearly all of them describe some way in which the individual "impinges" on other persons. They do involve some fairly salient, observable behavior and behavior which is likely to be noted because it is public and more often than not bothersome. The most frequent complaint was that the individual was violent in some manner, and the second most frequent complaints were of some form of social impropriety, e.g., urinating in public (a somewhat surprising complaint in the Philippines although it apparently means urinating openly without any regard to location), public nudity, or wandering aimlessly around the community. For two of the cases for which symptoms were given the individual was said to be kept tied up at home, suggesting that if his symptoms were known, they would be of the same nature as those reported for other cases. On the whole the list of symptoms provides a rather coherent picture of the barrio case of mental disorder, so much so that there are almost no symptoms reported which would seem to be unlikely accompaniments of other symptoms. None of the symptoms is really incompatible with any other. However, it should be noted that one non-symptom was reported for seven patients, i.e., they were specifically described as "harmless," a description incompatible with several of the more positive symptoms. But for the most part the barrio is one which would almost certainly be diagnosed as schizophrenic and with fairly marked tendencies toward acting out of impulses.

The small number of cases makes it of doubtful worth to look for joint occurrences of symptoms, especially since the symptoms which are most frequent will have a greater probability of occurring together. However, such analysis as was possible showed that being violent, talking to oneself, and wandering aimlessly have some tendency to cluster, and wandering aimlessly, talking to oneself, talking nonsense, and committing social improprieties have a tendency to cluster. The main difference between the two sets is that one is characterized somewhat more by violence, the other by lack of concern for social acceptability of behavior. Being violent occurred in conjunction with 16 of the 26 other symptoms.

An interesting omission is that no instances of hallucination were reported, and unpleasant delusions were reported for only two cases, one being the delusion of a young, unmarried mother that her child was being chased by a man with a bolo (suggesting some hallucinatory possibilities), and the other being of a man who was frightened often by the fear that there were men under his house who might do him harm. Proba-

bly hallucinations and delusions are simply far less likely to be known to those not immediately associated with the victim than are many other kinds of behaviors. For one thing, they are not, unlike most of the reported symptoms, directly observable but must be inferred from other behavior, often ambiguously. Much the same can be said for the very low frequency of reported sleep disturbances, a symptom with notably high frequency among patients under treatment (Sechrest, in press).

Even the brief descriptions of the cases made it evident that most of them would be diagnosed as psychotic, but some few might have been mentally retarded. Two cases merit special mention on that score. A man and his wife were said to be insane because they took poor care of their children and often carried them around naked. In addition one of their children had died of pneumonia, supposedly after being carelessly bathed in a cold stream. The husband was said to have three "abnormal" brothers. There were two other cases which came from families with one or more other "abnormal" siblings. A woman who was said to have killed a cat by biting it "during an attack," came from a family of seven, only one of whom was "normal" according to the informant. Another woman with two "insane" sisters who were dead reportedly tried to bury her child alive and several times attempted to throw the baby out the window of her house.

Folk theories of mental disorder

Informants often volunteered information concerning the probable "cause" of insanity in the cases they were describing, and they were asked a specific question about the ideas that people hold about causes of mental disorder. However, the analysis which follows is based only on hypotheses about specific cases because the interview question did not reveal anything not well documented by the voluntary reports. In the data to be reported the number of possible causes is far greater than the number of cases because informants often gave multiple causes, or they reported rival hypotheses. The reported causes of insanity for all cases described, both current and noncurrent, are given in Table 2.

The most popular folk theory of serious mental disorder is that it is attributable to *pasmo*, a Visayan term probably derived from the Spanish *spasmo* which means "spasm." Pasmo[3] is used in Negros Oriental to refer to what is believed to be a rather distinct syndrome which is caused by overwork and hunger, or possibly also becoming chilled as from breezes or dampness. It is said to be characterized by "hardening" of the muscles, and from all accounts the common belief is that the muscles do literally become hard and stiff. Pasmo is also believed responsible for cases of mental disorder of various kinds, both severe and mild, but mental disorder is not the inevitable outcome of pasmo. People are susceptible to pasmo both from economic deprivation and from personal conscientiousness that makes overwork and un dereating likely. For 22 cases pasmo was mentioned specifically as a possible causal factor, and one additional case was included in that category since the cause was given as "poverty and hunger." It is of considerable interest that one informant stated that pasmo was the causal hypothesis favored by more educated persons and that they were led by that theory to seek regular medical help as opposed to folk treatment to be described in a later section.

What the true nature of pasmo is, and indeed, whether there really is such a syndrome, is unknown at this time. However, from all reports it is a fairly common form of illness among the lower classes in Negros Oriental, and it can afflict males and females alike.

The second most frequently expressed hypothesis with respect to insanity is that it is hereditary, that being explicitly stated as a possibility for 20 cases. In most instances when heredity was mentioned as a cause, the informant noted that there were other distinctly abnormal individuals within the nuclear family, i.e., either parents or siblings. In two instances heredity was justified as a hypothesis on the ground that the person in question had "always" been ab-

Table 2

The causes of insanity as given for specific cases by teacher and barrio official informants.

Cause	*Number of cases*
"Pasmo"	23
Heredity	20
Post-illness	9
Spirits	7
Sorcery	3
Problems in love and marriage	7
Death of loved one(s)	6
Phases of the moon	5
Menstruation	1
Business pressures	1
"Nervousness"	1
Excessive drinking	2
Too much fear during war	1
Worried about inheritance	1
Inability to continue schooling	2
Pregnancy	1
Birth of illegitimate child	1
Too much studying of Latin	1
Being too bright and ambitious	2
Injuries from repeated fighting	1
Wrestled and fought with insane sister	1
Hatred of step-mother	1

normal in some respect. The mentioning of heredity did not rule out other hypotheses, and in half of the 20 cases the informant was explicit in advancing heredity only as a very tentative hypothesis and accompanying it by an alternative, e.g., "It could be heredity since his parents were a little crazy, but others say that it is pasmo." In any case, among these relatively well-educated or "elite" members of the barrio community, heredity is given recognition as a causal factor in mental disorder.

Nine cases were attributed to the effects of illness, and for only two of the nine was any other hypothesis offered. The three illnesses implicated were: typhoid (five cases); malaria (three cases); and cholera (one case). Apparently when there is some definite disease involved, there is very little inclination to look for alternative explanations. Generally the informants were quite positive in their assertions about the disease causing the insanity.

The malignant effects of spirits or "unseen people," were mentioned in seven cases, usually with the explanation that "other people" said that spirits were the cause. However, one barrio official and one teacher gave straightforward accounts of insanity caused by spirits without implicitly either accepting or rejecting the ex-

planation on a personal level. Aside from the term "unseen people," the spirits were referred to as *Yutan-On* and *incanto.* Spirits were thought to have caused insanity because they were offended, in three of the four cases where a detailed explanation was given. One person was said to have picked up something from a place inhabited by unseen people, one person took a bath in a pool beside one of their trees (spirits are usually thought to inhabit trees), and one young man who made his living by harvesting coconuts experienced what must be an occupational hazard by climbing inhabited trees. The fourth case was quite different in that a young woman was thought to have become insane because she was courted by an incanto. As will be seen later, the treatment for those attacked by spirits is rather specific.

Three cases were attributed to sorcery, a phenomenon rather widely accepted in rural Negros Oriental (see Lieban, 1960). In two cases no additional explanation was given, but in the third case a girl was said to have become insane after drinking a love potion given to her by "a Moro."

Problems in marital and love relationships were thought to have been causally involved in seven cases, and in six of the seven cases the problem was of a broken love affair or marriage. However, in the seventh case a man was described as "defeated" because he was never able to find a wife to marry. The demoralization stemming from his low status in his community produced the insanity. An additional six cases were attributed to the death of loved ones a fairly short period of time before the onset of the insanity. Three cases involved the death of children, one of husband and children, one of husband, and one of wife, the latter an accidental death by lightning. Typical of the concept of multiple causation was the case of one man whose insanity was attributed to the facts that his children died and that his wife left him.

The last category of any size consists of cases whose disturbances was attributed to phases of the moon. They included both males and females, and the full-moon was mentioned specifically for two of the five cases. One other case seemed to involve the period just prior to the new moon. In no instance was there any rationalization of the effect of the moon; it was merely asserted that episodes of insanity were related to phases of the moon. An additional female case was attributed to her menstrual cycle, again without further explanation. Such obvious, periodic natural events offer appealing hypotheses and are probably widely used for explanatory purposes in undereducated groups. That the effects may be genuine should not be dismissed as a possibility, as the work of Petersen has shown (1947).

Finally, we are left with a number of hypotheses advanced for only a few cases and not easily categorized. Two cases were attributed to excessive drinking and another case was thought possibly to have been caused by injuries suffered in repeated fights. Pregnancy accounted for one case and the stress of bearing an illegitimate child of another. Business pressures, inability to continue schooling for financial reasons, and the experiencing of too much fear during the war accounted for other cases. An additional case was thought to stem from too much intensive study of Latin under the village priest, and two sisters were said to have been too bright and ambitious for their own good. We are left with the interesting explanation of one woman's insanity that she hated her stepmother too much, and the even more interesting explanation of a young woman's insanity as having been the result of wrestling and fighting with an insane sister. In the latter instance there is some implication in the account of a mysterious transmission of insanity through contact rather than of the mere stress of fighting.

We can see that many of the "causes" to which insanity is attributed in these barrios involve psychiatrically suspect notions and even outright superstitions of a venerable nature. However, in most instances the explanations given depend upon the operation of some fairly severe stress in the individual's life. Pasmo, of

course, is considered to be a physical stress of some severity, and apparently it is considered sufficient to produce insanity. Certain diseases are also seen as capable of producing insanity as a sequalae. But most of the stresses aside from pasmo are of a psychological nature, and they include both continuing, e.g., worried about an inheritance, and traumatic, e.g., death of wife by lightning, events. In any case, these causal, or perhaps "precipitating" factors, are not so much different from those often adduced by more sophisticated and even professionally trained persons. Several of the "causes" mentioned by this Filipino sample are very similar to those found among the Yoruba in Nigeria although the latter seem to have more ideas which are scientifically and psychiatrically rejectable (Leighton et al., 1963).

Winslow (1944) has described three general categories into which prescientific theories of disease may be cast, and the Philippine barrio theories fall into two of the three categories. One general theory of disease is the "demonic" theory, i.e., that disease results from malevolent spirits or forces. Winslow believes the demonic theory to be the prevailing theory in all primitive tribes. There are three types of demonic influence: (1) those emanating from living human beings, either in the form of bewitchments or from persons with malevolent dispositions of which they are unaware; (2) souls of the dead; (3) non-human spirits, e.g., of animals or plants. It would appear that most of the instances of "spirits" noted here involve human or near-human forms, perhaps souls of the dead. But sorcery is also mentioned and it presumably involves a malevolent human influence.

The second prescientific general theory of diseases is that it is an expression of the wrath of an essentially righteous god, usually for sin. No instance was found of such a causal hypothesis although more pointed questioning might in some instances have revealed something close to it. However, the notion of sin and guilt does not seem especially salient in the Philippines, and a disease theory based on such concepts might not be a very powerful one.

Finally, Winslow suggests that many conceptions of the cause of disease involve a metaphysical science which assumes that there are occult forces beyond the framework of the physical universe, but presumably still orderly and predictable, not capriciously operative. A good case in point is the belief in cosmic forces such as phases of the moon and sun or of the stars. The mode of operation of some sorcerers, perhaps even most, is also understandable in terms of metaphysical science. For example, two different informants said that a sorcerer could work by making a small wax figure of his victim and then stick pins in it, melt it, bury it, or something similar. Winslow notes that magnets have long held great interest as tools for treating disease, and much sympathetic magic is based on a metaphysical science.

The treatment of mental disorder, as with any condition, is highly likely to follow from the conception of its cause, and that is certainly true with respect to the cases studied here. As will be seen below, the treatments do reflect both the demonic and metaphysical scientific theories, the latter somewhat more than might be expected from the apparent frequency of such theories. However, it seems likely that theories are held to operate at different levels, and one may hold to both a scientific causal theory and a metaphysical treatment procedure.

It would be going too far to say that the remainder of the theories advanced are really scientific rather than prescientific. For one thing, many of them, even if they do not involve any of Winslow's three prescientific theories, are not thereby automatically established as scientific. As Leighton *et al.* (1963) found, "heredity" does not necessarily mean to an illiterate informant what it means to a Western-trained scientist, and we cannot be sure that when barrio Filipinos regard mental disorder as "inherited," that they have in mind a scientific, genetic notion. The Yoruba were found to have a concept of disease as having a life and will of its own, and they conceived of the possibility of a

disease lying dormant within persons, perhaps over generations until it found the right victim. Such a concept is, perhaps, implicit in the case described of the girl who became insane because she wrestled with her insane sister which permitted the disease to transfer to her.

Nonetheless, such causal "theories" as that mental disorder can come about as a sequelae of a serious illness, as a result of severe frustration, or as a consequence of psychological trauma are not opposed to the views of much of modern psychiatry, and they are as "scientific" at an apparent level as most of our current theories.

Treatment of mental disorder in Negros Oriental barrios

Both teachers and barrio officials reported the same kinds of treatments of cases of mental disorder in their communities, but the barrio officials, as might be expected, seemed to know more about local, indigenous healers and their methods. However, as in other tables the overall findings have been combined for teachers and barrio officials and are given in Table 3. All instances of treatment were recorded, whether for current cases or not, and for some cases multiple treatments were mentioned and recorded. The outcomes as given are those judged by the informant, and no pretense is made that they are valid.

The modal treatment is clearly by the local, "native healer" as might be expected, but for a rather surprisingly large number of cases it was specifically stated that no treatment was given, a point to be discussed later. The "treatment" of restraining an individual by tying him to his house is given only as a matter of interest. Tying a patient was not regarded as positive treatment in the sense that it excluded a case from the no treatment group. A fair number of cases were specifically said to have been forcibly confined to their homes, and it is quite likely that many more were similarly confined without it being known to the informant. Other observations by the writer indicate that it is a common practice in rural areas. Afflicted individuals are said to be confined both for their own protection (usually in the case of females) and for the protection of others, but the confinement lasts only as long as necessary. Because so many of the cases are episodic, temporary confinement is not necessarily an undesirable way of managing them. It will be noted that an outcome was not specified as a consequence of tying a patient, a fact

Table 3

Treatment of cases of mental disorder as reported by teachers and barrio officials.

Type of Treatment	*Number of cases and outcome*				
	Favorable	*Equivocal*	*Negative*	*Unspecified*	*Total*
Sent to National Mental Hospital	2			5	7
Sent to Manila				2	2
Local medical or hospital	2	1	5	3	11
Imprisoned				1	1
Tied in or to house				19	19
Local "healer"	6	1	13	13	33
No treatment given	2		6	12	20
No treatment mentioned				8	8

that probably reflects both the incidental way in which tying a patient was often mentioned, and the episodic nature of the cases which may in the minds of the informants ruled out any question of outcome.

Some few cases were noted to have been treated in the National Mental Hospital, and two additional ones were "sent to Manila" but not to the N.M.H. An additional few patients were known to have been treated either by a local M.D. or in the provincial hospital. One case had involved a killing, and the man had been imprisoned for his act.

Another way of looking at the data is in terms of the types of treatment employed as a function of the causal theory concerning the case. Unfortunately, most of the cell entries are too small to be of interest, but pasmo, heredity, and spirits-sorcery tend to be associated with native treatment. Six of seven cases involving sequelae of physical illness were treated either by the local medical facility or by the local medical facility *and* the native healer. We are left with with "other" causes, most of which, it will be noted fall more into what we might call the "psychological" theories, e.g., frustration, trauma, etc., and this category is most strongly associated with no treatment. Apparently a fairly sophisticated psychological conception of mental disorder doesn't lead to any treatments imaginable to the barrio folk who have to deal with such cases. It might be of interest that pasmo and heredity each were involved in seven cases for which treatment was denied to have taken place. One teacher informant said, "Sometimes they are treated by a [native healer], especially if the family believes the cause is supernatural, by unseen people. But the educated who think it is pasmo may get a doctor."

Seven barrio officials and 15 teachers made specific statements concerning the efficacy of native healers. One additional barrio official stated his belief that a local physician could cure mental disorder. Four of the seven barrio officials thought that native healers could cure at least some cases of mental disorder although one carefully qualified his judgment by the proviso "if he is really good." Two of the other officials were doubtful about the efficacy of native healers and the remaining one was negative in his estimate. That their judgments were reasoned and thoughtful is indicated by such comments as:

> There are reports that treatment by the local [native healer] helps, but somehow the insanity comes back again.
>
> Some reported relief from the local men who are believed to have the ability in treating these conditions.
>
> He was treated by both the doctor and the [native healer] so it is difficult to say which treatment made him better.
>
> There is none here who is good in treating the insane.

The above comments indicate awareness that ability to treat the insane is a special ability which not all native healers have, that allocation of responsibility for cure is difficult, and that apparent cures may not be permanent.

The judgments of the 15 teachers included five which were favorable toward native healers and only two which were clearly unfavorable, the remaining eight being equivocal. However, four of the equivocal judgments were of the "not sure" variety while the other four were equivocal because the teacher said that the healer might be able to help some persons but not others. Thus, nine of the 15 teachers thought that the healers might be helpful with at least selected cases while only two were clearly negative in their judgments. It is interesting that teachers often used the word "quack" to describe native healers while the barrio officials never did. The term "quack doctor" does not have quite the same pejorative significance in the Philippines as in other countries, but it probably still carries negative connotations when used by educated persons. Both the teachers who were unfavorable in their judgments used the term quack, but then so did three of the five who were clearly favorable.

In their comments the teachers indicated awareness of some of the same aspects of native healing of insanity as the barrio officials. Three of them mentioned that the help achieved was

only temporary. Another commented that "Sometimes they [get better], but I think it's more of faith healing if the quacks ever help at all." That was the only indication of any awareness of the "suggestive" or "faith" aspects of healing. Still another teacher made a comment which is apparently remarkably similar to an attitude often found in other places and among far more sophisticated people: "Some are relieved or cured by the [native healer], and others are hopeless."

The nature of native healing efforts. There were three common terms by which native healers and healing were referred to. Healers were, as indicated above, often called "quacks" by the teachers, but the local term was *mananambal.* Most of the barrio officials used that term. In addition, healing was often referred to as *the Binisaya way*, meaning the Visayan or local way. Less commonly native healers were called *hilot* or *manoghilot*, but as will be seen below, the distinction is a meaningful one in terms of the type of treatment used.

The *mananambal* seems to be characterized by the use of herbs and roots, frequently called *gamut.* The only plant material mentioned specifically was the *tugas,* the inner, hard part, of the molave tree. Herbs and roots are boiled and the tea is taken internally, but some mananambals wrap leaves around the patient's head. It is difficult to be positive about the causal theory on which such treatment is based, but the use of herb infusions is not necessarily prescientific while wrapping leaves around the head probably involves some metaphysical scientific theory which makes it seem likely that the illness can be driven out of the head in that manner. Mananambals were often described as using multiple treatments, gamut being only a part of the total program. Other methods involved "whispering" ceremonies, *hicap* (touching), prayer, *tawal* or *huyop* (blowing the breath over the patient's body), and, in one case, massage. In one case the mananambal forbade the patient to eat pork and certain kinds of fish. There was one local healer who was said to use "human electricity," and the informant who reported it claimed to have experienced the healer's electricity himself. He was said to be able to produce a sharp electric shock by touching a person with his fingers. All the above treatments with the exception of prayer seem to be compatible with either a metaphysical scientific or a scientific conception of the cause of mental disorders, although the whispering treatment might involve some demonic or theistic theory. Some healers were described as *hilots,* apparently meaning that they relied predominantly on massage.

Both a teacher and a barrio official described one case each in which the treatment involved a *dlwata,* a type of quasi-religious ceremony. In each case the native healer arranged a ceremony in which food, including pig and chicken, was offered to *incantus* to propitiate them. Such treatment obviously is based on a demonic causal theory and is one of the three main types of treatment given by Winslow as stemming from demonic theory, viz., (a) propitiation, (b) exorcism, and (c) evasion or trickery.

In two cases barrio officials described native healing being attempted by family members related to the afflicted person. In both instances the explanation was that poverty precluded regular treatment so family members attempted to use methods they had seen used by healers. One case involved a husband who was treating his wife with "local medicine" he had learned by watching a mananambal hired to treat his wife, and the other involved parents who were giving their daughter "roots" which were all they could afford and which they hoped would help her.

Failure to treat cases in the barrio. As was indicated above a number of cases were specifically described as not having received any treatment, and in additional cases no treatment was mentioned. There appear to be several reasons why treatment may not be given to persons who become mentally disordered in a Philippine barrio. First, patients may not be treated for economic reasons. Several informants mentioned that native healers were often resorted to be-

cause money was not available for medical treatment, and we have already noted that some patients were being treated by some approximation to the Binisaya way practiced by relatives because even native healers could not be paid. Undoubtedly there were other cases not being treated at all for economic reasons. Particularly for long term, often chronic disorders and for those involving repeated episodes the economic strain imposed even by local treatment methods can be too great.

A second reason that treatment may not be given is that it may be unavailable in the circumstances. One informant reported two cases as untreated because, "There is none here who is good in treating the insane." One other young man was said to be going untreated because of his violence which not only made if difficult to take him to be treated but which made him unacceptable as a patient to the healers available. Thus, treatment was unavailable to him because of his behavior rather than for any other reason.

A third and rather frequently mentioned reason for not treating cases of mental disorder is that treatment may be regarded as futile. Particularly in cases seen as hereditary treatment was likely to be neglected. Several informants commented as follows:

Not treated because his is inborn.

She was not given any treatment because this is believed to have been inherited. . . .If people believe it's due to heredity, there is nothing done for them.

A hereditary causal theory seems to contribute to a feeling of hopelessness. However, the futility of treatment also is associated with chronicity of the disorder:

Those known to be insane for many years or since birth are left alone.

Has not been subjected to any treatment because she had this sickness since she was young.

A fourth reason for neglecting treatments is a callous attitude toward the patient. Three such instances were reported. In two of the cases female patients were neglected and left untreated because they were regarded as useless anyway. Almost certainly such attitudes would be associated with an attitude of futility about the prospects of treatment. Paradoxically, the third case involved an accusation of neglect of treatment for the opposite reason, the fear that it might be effective. A man who was a school teacher became mentally disturbed in a fairly distant place and was brought back to his home barrio to be cared for by his family. Reportedly they refused to have him treated for fear that if he were cured, he would simply return to his teaching job and his wife would just get all his money. That accusation was never verified, but it is interesting nonetheless.

Finally, and of great interest, is the fact that "treatment" may be thought unnecessary in cases resulting from pasmo. Both a barrio official and a teacher gave similar views:

I think the best way to cure these people is to give them enough food to eat because I believe many of them became insane due to hunger.

Others need only proper food so they don't suffer from hunger. I have tried to do this to some cases who are about the become seriously insane, and they get better.

The belief of many persons in pasmo is strong, and the pasmo theory carries with it a fairly obvious prescription for treatment of sorts. Perhaps a better diet may be of help in many such cases, especially if it is associated with attention and loving care within the family and community.

Lesser forms of mental disorder recognized in the barrios

Informants were asked about milder forms of mental disorder in their barrios, and all of them purported to know what might be meant by the question. In general the responses of barrio officials and teachers were the same, but teachers were more inclined to deny knowing of any such cases in their barrios or to be indefinite in their estimates as to the number. Seven of the ten barrio officials gave numerical estimates of the number of cases known to them, and they averaged about five cases per barrio, but the range was from one to ten. Only eight of the teachers gave numerical estimates, and they averaged about seven cases per barrio, again

with a range from one to ten. Ten of the teachers indicated that there were such cases in their barrios but gave indefinite estimates, e.g., "several," "not many," and "a few only."

As shown in Table 4, a total of seventeen different terms was used to refer to milder forms of disorder. The teachers used a somewhat wider variety of terms, and there is some suggestion that they recognized a wider range of disturbances. Although the number of different terms used was seventeen several appeared to be used as synonyms, and informants sometimes mentioned that people used them interchangeably. Moreover, there was fairly good agreement in the behavioral descriptions associated with the terms.

The key term is very obviously *kulang-kulang.* The word *kulang* means "lacking" or "incomplete" in the Bisayan language, and the behavioral descriptions of kulang-kulang make it evident that it is used primarily to refer to persons who are probably mentally retarded or who are of a "simple" nature even if they have some psychotic features. The terms "28" and "19" are used in the same way, and both connote "lacking," "28" because February lacks some days, and '19" because it lacks one of being twenty. (The term "99" is similarly used.) *Inocente* is another obvious synonym for kulang-kulang.

The descriptions of persons who were kulang-kulang included the following: childish, speech defects, talks about senseless things, peculiar habits, cannot rely on what he says, easily swayed or persuaded, easily gives in to flattery, begs, sleeps late, does not bathe and brush teeth. Two informants specifically indicated that the condition is not regarded as serious. The only discrepant description was of one individual who

Table 4

Terms used by informants to describe lesser forms of mental disorder.

Term	*No. of teachers using*	*No. of barrio officials using*
Kulang-kulang	16	5
Buang-buang	6	2
Siyot-siyot	3	3
Mini-mini	3	0
Olog-ologan	4	0
Pahong-pahong	0	2
Inocente	0	2
May sínko sa ilok	2	0
28	2	0
19	1	0
Feebleminded	1	0
Na tarantar	0	1
Bulanon	2	0
Kuluha-on	1	0
Kuluhiton	1	0
Kulugmatay	1	0
Epileptic	2	0

was said to be quarrelsome, drinking, and boastful. In general it seems safe to conclude that most cases of kulang-kulang involve mental retardation. One teacher used the term "feeble-minded" and likened it to kulang-kulang and *mini-mini.* While two informants said that it was inborn, one said that people believe it can result from enemies who hold a *sang anton,* a ceremony in which oil is poured to a santissimo in a church or in which oil, along with other ingredients, is boiled until it evaporates. One other informant, a barrio officials, opined that kulang-kulang could result from head injuries.

Terms apparently closely related to kulang-kulang because they were used in the same context and because the behavioral descriptions were similar are: *siyot-siyot, buang-buang, pahong-pahong, mini-mini,* and *olog-ologan.* The writer has now seen five male cases described as buang-buang, and all five were dirty, dressed in ragged clothing, had excessively long hair, and were wandering aimlessly along the road. There is some suggestion of differential use of the terms mini-mini and olo-ologan. One informant implicitly differentiated between kulang-kulang and mini-mini by describing the former and then saying that there were also cases of mini-mini. One case of mini-mini was said to be "a young man who liked to think of girls, especially if they have stores. He will deposit money with them to have an excuse to hang around. He boasts to others that the storekeeper is his sweetheart." Another mini-mini was said to like to show off with his best clothes on rainy days.

Olog-ologan seems to be similar to the Malayan *latah* and to what in other parts of the Philippines is called *mali-mali* and *oto-oto.* The olog-ologan is said to obey immediately what they are told to do without thinking, especially if they are dared or flattered. Moreover, there is some indication of the irritability often noted in conjunction with latah. One 55 year-old male olog-ologan was said to be provoked to violence by someone saying "gaddem" to him.

May sinko sa ilok is a rather unusual expression since it is translated as "to have five in the armpit," but Bisayan-speaking informants all recognize it as meaning "a little off his mind," "loco-loco," etc., although it is not certain that it is used in quite the same way. One teacher suggested that may sinko sa ilok could result from pasmo or malaria, both of which are prominently mentioned as causes of "insanity."

Bulanon and *kuluha-on* are of interest because both are believed to involve a connection with phases of the moon. In fact, *bulan* is the Bisayan term for moon, and bulanon means "affected by the moon." One informant described a case of bulanon as a young woman who is ordinarily very industrious but who, when attacked, does not work and sings from morning to night. She says she does so because she is lonely. She is always harmless. It is difficult to know in just what psychiatric category such a case should be placed.

Na tarantar is apparently considered to be a mild derangement with much nervousness, fear, and irritability. The word *tarantar* is of Spanish origin and has the same root as *tarantado,* a Spanish term for mental disorder. The root refers to the tarantula spider which was once thought responsible for the well-known "dancing mania" which swept Europe periodically during medieval times. Other informants from the Visayan area know the term *na tarantar* but the writer has not encountered it elsewhere in the Philippines. The one case of *na tarantar* referred to by a barrio official was said to have been a maid in Zamboanga and to have become heavily indebted to her master. When she left his employ without discharging her debt, he hired a *Moro* to make her insane. Later she was cured by *hicap* and prayer.

Kuluhiton and *kulugmatay* were conditions mentioned by one teacher each. The *kuluhiton* is said to be sensitive and easily provoked to violence, a description that is reminiscent of the term *barumbado* used in some parts of central Luzon and referring to impulsive aggressiveness. *Kulugmatay* was said to be due to hunger, and the victim "dies" temporarily, his mouth bubbling with saliva. Other informants from the

Visayans did not recognize the term, and more investigation is called for. It could refer to a mild epileptic seizure.

Epilepsy was mentioned by three informants as a form of mental disorder. One specific case was described as irritable; especially when called by a certain nickname he was likely to throw stones at people. The other specific case was said to be unable to "talk straight" in addition to having seizures.

Thus, various "mild" forms of mental disorder are recognized at the barrio level, but clearly the bulk of the cases probably involved some degree of mental retardation. Aside from that suggestibility and irritability seem to be the outstanding symptoms. There are no cases described which would fall within the usual "neurotic" categories with the possible exception of *na tarantar,* which could easily be an anxiety reaction. Whether such disorders as obsessive-compulsive and hysterical exist but go unrecognized as abnormal it is not possible to say. However, our informants were intelligent and many were quite sensitive, and it is scarcely to be imagined that there are many or dramatic cases of typical neurosis which they would not have mentioned.

Amok

All informants were questioned specifically about *amok* since it is often mentioned in connection with Philippine psychopathology. However, few informants knew of any such cases in their barrios, and the specific cases mentioned often went back many years. Several informants stated that while there were killings in their barrios, they did not involve *amok* since they were motivated by grudges and other known causes. Two barrio officials and four teachers described cases which they thought of as *amok* but none were recent and one had actually occurred in a neighboring barrio. Very evidently amok is a rare occurrence in Negros Oriental.

Conclusions

The foregoing presentation is meant to provide an impetus for further studies in a critical field that has been all but totally ignored. For too long has a narrow view of mental disorder and its management been accepted without objection, and that view is that mental disorder represents a set of disease processes which cannot adequately be managed without psychiatrically sophisticated intervention. It is nearly safe to say that most workers have assumed that where psychiatric enlightenment is absent, there is only chaos and abysmal ignorance and helplessness.

We believe that, as crude as they are, the observations described here suggest quite a contrary picture. There are folk theories of mental disorder, and those theories lead to attempts at management which are rational, given the premises. One way or another most cases are dealt with in a positive manner, and where no overt treatment is resorted to, there are good reasons for the failure. We are not in a position to attest to the efficacy of indigenous treatments, but it should be emphasized that knowledge of specific instances of failure, even if numerous, are not a sufficient basis for a negative view. No healing profession can stand to be judged by its failures.

Mental disorder does not appear to be a grossly serious problem in the barrio level. Cases do not appear to be intolerably numerous, and most are managed in one way or another without more than transient community disorganization. Public administrators would do well to have a complete understanding of community problems and priorities in planning for amelioration. Despite the pity understandably aroused in individual cases, mental disorder may rank relatively low as a problem to be solved in rural communities. It should also be noted here that the usual solution of supplying more psychiatric facilities by no means guarantees relief.

We believe that relatively few cases of mental disorder go undetected in the small, closed communities of the type studied here, the frequently suggested image of large numbers of psychotic persons secreted at home by sensitive relatives seems absurd in the context of Philippine barrio life. Moreover, four informers seemed quite aware of the nature of what we call mental dis-

order in both its serious and milder forms. As the writer has suggested previously (Sechrest, 1964, in press) it seems that mental disorder in the Philippines is likely to involve salient, socially bothersome symptoms.

The treatments described as typical in barrios are not always in the liking of those with a modern psychiatric orientation, but they are not completely irrational in most cases and perhaps are not even ineffective when judged by scientific standards. As many psychiatrists now recognize the effects of suggestion are an important component of nearly all medical therapies, and for some suggestion is probably about all there is. If patients and their families believe in *hicap* and *diwata,* then those treatments may well be as effective as any other. Often the treatments described here have the advantage of being inexpensive and of keeping the victim in his own family and community. If the treatments fail, little will have been lost, and if they succeed, much will have been gained at little cost. As the writer has pointed out elsewhere (Sechrest 1967), there is reason to believe that mental disorder among Filipinos may tend to be episodic, thus insuring recovery in many cases, if the patient is not disturbed by separation from his family and friends and by incarceration.

Finally, the terms used to refer to mental disorder are interesting and seem to reflect the fundamental views held by a community about the nature of the problem. The imagery, e.g. of mental disorder as childishness, is interesting, and contrasts with other areas, e.g., where the imagery of "brokenness" is prevalent, may prove instructive.

FOOTNOTES

1. The writer wishes to express appreciation to Pedro Flores for conducting all but three of the interviews. All interviews were conducted in English with Visayan being used where necessary for clarification of either questions or answers.

2. In this and other tables findings are grouped somewhat by content rather than being ordered by frequency.

3. In a sample of 5263 residents of Negros Oriental during 1958 Pal (1963) found that 10 persons were said to have suffered from pasmo during the year. However, they averaged 53.7 days of illness, indicating that it is a fairly severe disorder. Of thirteen common illnesses, only asthma produced a higher average number of days of illness, 58.1 for 13 cases.

APPENDIX

Interview Schedule

1. Do you know what it means to be insane?
2. Have you ever known anyone who was insane?
3. Where do you live, exactly? That is, what is the name of your place of residence?
4. How many other families would you estimate live in this place?
5. And about how many people live there, then?
6. How long have you lived there? Do you know pretty nearly everyone in your community?
7. Are there now any insane people living in this community?
8. Have there been any insane people who have been taken out of the community, for example, to a hospital or to live with other relatives?
9. How many cases of insanity have you known about in this community within the past five years?
10. When people become insane here, what is done for them?
11. What do people living here think are the causes of insanity?
12. Are *herbolarios* ever called in? Does it seem to help? Do other people believe that it helps?
13. Are there other kinds of mental disturbances that maybe aren't really insanity but that show that something is wrong with the person. Tell me about them.
14. How many such cases do you know of in your community right now?
15. How many such cases have you known of within the past five years?
16. Have you ever heard of *amok*? Has there ever been an *amok* in your community? Tell me about him.
17. Do you think there are more cases or problems such as we have been talking about or fewer or about the same in your community as compared with others you know about around here?

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