

Medieval visions and contemporary hallucinations

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SYNOPSIS The hallucinations of 23 patients with predominantly religious themes were compared with descriptions of visions from the Middle Ages. Although there were many points of similarity between the two classes of phenomena, none of the medieval visionaries was identified as mentally ill. The role of cultural norms in determining the attribution of mental illness, and the limitations of Euro-American criteria of psychoses, are discussed in the light of these findings.

INTRODUCTION

The paper reports on a study which compares 134 visions reported and written down in Medieval Europe with the religious hallucinations of 23 presently hospitalized patients in Minnesota. There are several controversies in psychiatry about the role of cultural factors in symptom presentation and recognition to which these data are relevant: we shall focus our discussion on one of these issues.

Do the forms which schizophrenic symptoms manifest in different societies differ or remain constant and universal? To rephrase this, where were Kraepelinian, Bleulerian and Schneiderian symptoms before Kraepelin, Bleuler and Schneider identified them?

Although the medieval and contemporary data encompass many other conditions, schizophrenia remains the enduring puzzle in psychiatry. For this reason we shall examine our data with reference to schizophrenia, always holding before us the question of whether our analysis sheds any light on the presentation, diagnosis and incidence of schizophrenia across time and societies. Our rationale for suggesting specifically that a comparison of medieval and modern data has relevance is as follows. If the prevalence rate of schizophrenia, taking into account the age distribution of the population and the mortality rates of schizophrenia, has remained stable even at a conservative 0·2-0·5% level (Freedman *et al.* 1975; Jablensky & Sartorius, 1975), this would

mean that from 2 to 5 of every one thousand people in the Middle Ages were schizophrenic. If we analyse medieval chronicles and other documents, we should discover how people in the Middle Ages wrote about people, some of whom we have reason to believe may have been schizophrenic and therefore may have had hallucinations. Conversely, the 23 patients in Minnesota reported hallucinations which correlate closely with what some people were said by contemporaries to have seen and heard in the Middle Ages. Thus the Minnesota patients report that they see Jesus and various saints; they believe that they themselves are Jesus; they receive commands from angels and devils. We agree with, and our data support, the observation of Jablensky & Sartorius (1975) that retrospective historial studies rarely go back further than the nineteenth century because of the limitations in identifying schizophrenia among the various psychotic states described. This precaution, although valid, should not discourage the extension of cross-cultural studies into historical-periods, but does call for, as Rosen (1970) has maintained, the same methodological rigour that is expected of contemporary studies.

A note of caution must be offered regarding the limitations in the types of inferences and interpretations that can be derived from the medieval material. The chronicles and saints' lives were not written for the purpose of setting forth detailed and accurate descriptions of the observed behaviour of madmen and first-hand accounts of visionaries. Probably without exception (a few of the authors are anonymous), these narratives were written by clerics who had

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very clear motives in committing a story or an observation to writing. The more common of these motives involved a partisanship towards either a nobleman or a saintly monk or bishop, accompanied by a wish to demonstrate the righteousness of the nobleman and the saintliness of the churchman – for example, by the narration of victorious battles and miracle cures. In addition, the narratives were meant to serve as *exempla* to instruct the reader in the necessity of behaving with Christian virtue. Occasionally, these works also tend to vilify an enemy or to criticize a powerful person through the seemingly innocent report of a dream-vision, such as a monk who in a vision of hell sees his neighbouring avaricious bishop roasting in the eternal fires. Some of the narratives are congeries of *topoi*, stereotyped pieces based upon biblical or classical examples, and therefore of more questionable value in regard to whether the event described either actually happened or happened in the way the author described it. Once these limitations are understood, two points in support of our use of the materials should be made. First of all, the authors had to write what was generally credible to their contemporaries; it would not enhance the reputation of a saint or magnate to have unbelievable stories told of them. Secondly, since the descriptions of insanity were used for purposes unrelated to a medical interest in the behaviour, there appears less reason to distort the description. The reader would judge the description by his own notions and acquaintanceship with insanity, and would not give credance to an outlandish or unrecognizable description. Thus, as with all historical data, we simultaneously accept it at face value and try to understand the forces that shaped the report handed down to us in the form in which it survives. We should bear in mind that a similar scepticism as we have for medieval sources can be applied to contemporary psychiatric reports. Certainly, criticism has been levelled at the case reports of psychoanalysts on the assumption that they have skewed their observations to support their theories. But the same criticism can be made about the biologically-oriented psychiatrists, or the type of worker who in general supports a particular thesis or world-outlook. One does not have to infer purposeful dishonesty to wonder about bias and values in determining the set with which we view the world. Thus there are inherent

limits in all sources and in all research designs; the more untrustworthy the source, the more cautious must be the design and the conclusions.

We have not included medieval medical writings on insanity in this article because several excellent studies are already available (Jackson, 1972; Clarke, 1975; Howells, 1975; Neugebauer, 1979), and we were interested in popular or 'folk' concepts and treatment rather than the repetition of humoral theories of mental illnesses found in the medical literature of the Middle Ages. It should be noted that with few exceptions before the later Middle Ages – and these few, such as Richer of Rheims and Fulbert of Chartres, have been well-studied (MacKinney, 1934, 1937) – the authors of chronicles, saints' lives and other forms of narrative works rarely give evidence of familiarity with the corpus of medical literature handed down from antiquity.

The questions and controversies regarding the universality of the presentation and the stability of the incidence of schizophrenia involve an obvious circularity which, without the discovery of some external validating criteria, appears unavoidable (Zubin & Kietzman, 1966; H. B. M. Murphy, 1968; Cutting, 1980). The calculation of the rate of schizophrenia will depend upon which symptoms are chosen as the diagnostic criteria, and the symptoms of schizophrenia which are chosen will depend upon the concept of schizophrenia. However, despite the many and obvious difficulties in comparing rates and types of mental illnesses cross-culturally, the generally accepted sense about the universality of schizophrenia is best summed up in the textbook of Mayer-Gross *et al.* (1977): 'There is nothing to support the view that large ethnic groups differ markedly in their liability to schizophrenic illness.' Nevertheless, there is a substantial body of data which questions this conclusion, and even suggests the converse. Part of the difficulty in evaluating the evidence is that two distinct methodologies are employed, with conclusions derived from one used as supporting evidence for the other. One methodology, exemplified by the works of J. Murphy (1976) and Westermeyer (Westermeyer & Kroll, 1978; Westermeyer & Wintrob, 1979a; Westermeyer, 1979, 1980) examines the presence of major mental illnesses, as defined by those cultures themselves, in non-western cultures. J. Murphy (1976) reported on mental illness among the Eskimo of northwest

Alaska and the Yoruba of rural Nigeria. She concluded that (p. 1027):

(i) phenomenal processes of disturbed thought and behaviour similar to schizophrenia are found in most cultures; (ii) they are sufficiently distinctive and noticeable that almost everywhere a name has been created for them; (iii) over and above similarity in processes, there is variability in content which in a general way is colored by culture.

In terms of prevalence, Murphy states: 'Patterns such as schizophrenia, *were*, and *nuthkavihak* appear to be relatively rare in any one human group but are broadly distributed among human groups' (p. 1027). Murphy finds, comparing her own rates with those of others, that they are similar from culture to culture. Westermeyer (Westermeyer & Sines, 1979) is more conservative in his conclusions, but similarly finds a core group of 35 persons in 27 villages who are considered *baa* (insane) by the villagers. A group of US psychiatrists and psychologists used Westermeyer's case reports and offered western clinical diagnoses for this group; the clinicians independently agreed on the diagnosis of schizophrenia in 10 cases. In an additional 12 cases there was a less than unanimous diagnosis of schizophrenia (Westermeyer & Sines, 1979).

The second methodology employed in cross-cultural studies applies western diagnostic criteria to indigenous populations. There are many hazards to this type of research, especially in relation to inaccuracies and misunderstandings in the translation of terms and concepts, and misperceptions of emotions (Leff, 1973, 1974). The most extensive work of this type is the WHO-sponsored International Pilot Study of Schizophrenia (IPSS) (WHO, 1975). This study investigated 1202 functional psychotics in 9 countries; 811 of these met ICD-8 diagnostic criteria for schizophrenia as well as a computer generated (CATEGO) diagnosis of schizophrenia. Unlike the subjects in the studies of J. Murphy (1976) and Westermeyer & Sines (1979), the persons studied were in hospital and already formally identified as patients.

From this series of studies, as well as other work, including an earlier study by H. B. M. Murphy *et al.* of a cross-cultural survey of schizophrenic symptoms (Murphy *et al.* 1963), several different and not necessarily compatible conclusions can be drawn. First, reliable diagno-

ses of schizophrenia and depression (Orley & Wing, 1979; Jablensky *et al.* 1981) can be made in different cultures, using a standardized interview schedule (Present State Examination), when applied by diagnosticians trained in the use of that schedule. Secondly, the content of the delusional and hallucinatory symptoms, and even the form of such symptoms, varies from culture to culture, leading H. B. M. Murphy *et al.* (1963) to state: 'it might be questioned whether the delusional systems which are the most familiar feature of chronic schizophrenia in Euro-American hospitals are an essential part of the disease process'. This point is supported by Littlewood's & Lipsedge's (1981) study of acute psychotic episodes in Caribbean-born patients in London. Many of the original diagnoses of schizophrenia, based upon the erroneous designation of culturally-supported belief systems as delusions, had to be revised as the course of the disorder evolved in either a more benign or a depressive direction. Thirdly, and most data seem to agree on this point, the course of the schizophrenic illness appears significantly more benign in non-industrialized than in industrialized countries. In the 2-year follow-up study of the IPSS 'on virtually all course and outcome measures, the group of schizophrenic patients from Agra, Cali, and Ibadan had on the average better course and outcome than the group of patients from Aarhus, London, Moscow, Prague, and Washington' (Sartorius *et al.* 1977, 1978). This variation cannot be accounted for by the variables usually used to describe psychopathology, sociodemographic factors and clinical predictors (type of onset, precipitating factors), thus leading to the tentative conclusion that other, as yet unidentified factors, must account for these cross-cultural differences. Waxler (1979), adding her own data from Sri Lanka and H. B. M. Murphy & Raman's (1971) data from Mauritius to the WHO data, concluded that the differences can be accounted for by social labelling theory, which attributes the poorer prognosis in industrialized societies to their pejorative and pessimistic attitudes towards the mentally ill. Torrey (1980), however, uses similar evidence to reach very different conclusions. He argued that schizophrenia is an illness of recent vintage, being practically unknown prior to the eighteenth century and in non-industrialized societies. He cited his own work from New

Guinea (Torrey *et al.* 1974) which showed that the native groups nearer to the cities had higher rates of schizophrenia. He maintained that this was not related to better case-finding in developed areas, but his argument in this regard is not compelling.

The complexities of the problems are such that the same data are sometimes cited by different authors to support contradictory positions. Torrey (1980) re-examined a study by Goldhamer & Marshall (1949) which is traditionally used to support the view that the frequency of the psychoses has not increased during the past 100 years, and concluded that their study really shows a very clear increase. J. Murphy (1976) cited Dunham's (1965) earlier study to support her view that schizophrenia rates are roughly similar world-wide, while Marsella (1979) cited Dunham's same study as suggesting 'that schizophrenia rates vary considerably across cultures'. The data showing a less malignant course for schizophrenia in non-industrialized societies could be construed as supporting Torrey's (1980) viewpoint (that schizophrenia is an illness of recent vintage in industrialized societies) by arguing that the good-prognosis schizophrenics are, in fact, not schizophrenics at all but have schizophreniform psychoses. However, the IPSS diagnoses (Sartorius *et al.* 1977, 1978) were based on strict symptomatological criteria and do not support this contention. In this regard, two final points must be made. The first is that there is no longer a question of whether schizophrenic symptoms change across time and cultures. We know that they do (Achté, 1961; Varga, 1966). The question rather is how we can continue to recognize schizophrenia if its presentation continues to change? Secondly, if we only consider hallucinations, it is possible that certain forms and types of hallucinations are pathognomonic of schizophrenia, or at least major mental illness, in industrialized societies, but carry no such specific diagnostic import in traditional societies where altered states of consciousness and altered modes of perception are socially sanctioned (Bourguignon, 1970; Al-Issa, 1977).

In our society, hearing voices and seeing things are generally viewed by public and professionals alike as *prima facie* evidence of mental illness. However, there has never been agreement about the significance of hallucinations in the diagnosis of schizophrenia (Sedman, 1966; Jansson, 1968;

Goodwin *et al.* 1971; Aggernaes, 1972a, b; Hare, 1973; Lowe, 1973; Larkin, 1979; Kräupl Taylor, 1981). It has long been recognized that hallucinations, as generic phenomena, are seen in a broad range of psychological and psychopathological states, including febrile, toxic, metabolic, infectious, ecstatic, sleep and sensory deprivation, trance, and functional psychotic conditions. One can be schizophrenic without experiencing hallucinations, and one can have hallucinations without being schizophrenic. The coexistence of the two can be said to be correlative, with the degree of probability of correlation seeming to depend upon the type of schizophrenia and the type of hallucinations.

In western Europe, from 500 to 1500 A.D., people who heard voices or saw visions considered themselves, and were considered by their contemporaries, to have had actual perceptual experiences of either divine or satanic inspiration. They were not considered mad and were not dealt with as such. In a previous paper we investigated descriptions of visionary experiences from a variety of sources from two historical periods within the Middle Ages and found only 4 descriptions which could reasonably be placed by today's standards within a functional psychotic or alcoholic category (Kroll & Bachrach, 1982). In addition to these 4 cases, 7 other visionary experiences seemed to occur within a context of malnutrition or severe fasting and 29 within a context of serious illness. In no case was the visionary experience (or the visionary person) viewed as psychopathological, although the medieval sources had no hesitation in labelling other people with other forms of behaviour as deranged.

In this study we have examined present-day hospitalized psychiatric patients whose major themes or preoccupations are of a religious nature, all of whom have had visions (by their own descriptions, hallucinations by ours). Our purposes are to compare the medieval and modern visionary experiences in view of the present controversy about the universality and specificity of schizophrenic symptoms across cultures.

DATA

There were 23 patients hospitalized in the past 4 years whose psychoses seemed to focus around

Table 1. Demography and diagnoses

	M	F	Total
Age range			
< 20	2	1	3
20–30	9	7	16
30–40	0	3	3
> 40	0	1	1
Religion			
Catholic	7	4	11
Lutheran	1	6	7
Other protestant	3	0	3
Pentecostal	0	1	1
Buddhist	0	1	1
Drug abuse			
Yes	9	2	11
No	2	10	12
Schizophrenia	5	4	9
Schizophreniform	1	1	2
Paranoid disorder	0	1	1
Drug psychoses	4	1	5
Bipolar mania	1	4	5
Depression	0	1	1

religious themes. Table 1 presents data regarding age, sex, religion, drug abuse and diagnoses. The majority of patients were in the 20–30 age range; they were approximately equally divided among men and women, Catholics and Protestants. Eleven patients used street drugs to a significant extent. This pattern is consistent with the base rate for young adults admitted to our psychiatric service and is a major source of contamination in diagnostic studies of young adult psychotics.

The question of what diagnostic label to apply to young adults who present with schizophrenic phenomenology but who have a significant drug abuse history pre-dating (as far as one can ascertain) the onset of psychosis is a vexing one. We are not speaking here of a transient psychosis temporarily related to a documented or acknowledged spree of drug abuse, but rather of the insidious onset of a delusional or hallucinatory state which follows chronic drug abuse, is accompanied by an amotivational syndrome or a deterioration in social and vocational functioning, and seems to persist weeks to months beyond the period of actual drug usage. The International Pilot Study of Schizophrenia sponsored by WHO excluded subjects with a history of drug abuse. The Feighner criteria (Feighner *et al.* 1972) exclude from a diagnosis of schizophrenia subjects who have used drugs within one year of the onset of psychosis.

However, these criteria are intended for research use and are designed to eliminate false positives even at the cost of false negatives. In clinical practice such stringent criteria offer little assistance in unravelling the complex nuances that confound considerations of diagnostic validity. Breakey *et al.* (1974) studied a group of 46 young adult schizophrenics: 14 had not taken street drugs; 26 had taken drugs prior to the onset of psychosis; and 6 had started taking drugs either after or contemporaneously with the onset of psychosis and were omitted from further study. Breakey *et al.* found that the 'users' all abused two or more drugs, had a significantly earlier age of onset of symptoms (19 v. 23 years) and an earlier age of first hospitalization (21 v. 25 years). The drug users were judged to have a healthier pre-morbid personality than the non-drug users. Because of the small numbers, family history data were not helpful in differentiating the two groups. Breakey's cautious conclusion was that the results are indicative of some precipitating role of drug abuse in the onset of schizophrenia. As Breakey pointed out, however, his study did not resolve the issue of whether drug abuse caused a schizophrenic psychosis in an individual who otherwise would *not* have developed schizophrenia. We have adopted a practical approach for assigning diagnostic categories in this study: we have diagnosed as schizophrenic those individuals whose schizophrenic symptomatology has persisted for at least 6 months after the apparent cessation of drug abuse and after at least one adequate trial of antipsychotic medication. Using these guidelines, almost half the patients ($N = 11$) received diagnoses of schizophrenia or schizophreniform psychosis, 5 patients were manic, and 5 had a drug psychosis.

A comparison of the religious visions and experiences in the Middle Ages and the present day reveals points of similarities and differences. The Minnesota patients were more likely to receive auditory messages interpreted as coming from angels and devils, while the medieval visionaries had more visions, both accompanied and unaccompanied by words or sounds. A young man in Minnesota heard popping and clicking noises in his nose. He was certain that these sounds were commands given to him by angels and devils. He would ask these spirits a question such as 'Is it all right to eat my lunch?',

and would act in accordance with his interpretation of the ensuing pops and clicks. On one occasion preceding hospitalization, he took a drink from a can of kerosene in response to the pops and clicks in his nose. Another patient heard the voice of the Virgin Mary telling him what prayers to say. A 32-year-old woman patient heard the voices of St John, St Mark and St Michael tell her that she is Jesus. A medieval example of an auditory 'hallucination' is given in the Book of the Foundation of St Bartholomew's Hospital, in which a sailor on board a ship caught in a storm hears a voice telling him that the other sailors are praying to the wrong saint and that he should pray to St Bartholomew. He does so and the storm abates. Many of the Minnesota patients who heard voices of angels or devils had difficulty in distinguishing between the two. In a few cases the person assumed it was an angel, but when the content became critical or ordered self-destructive behaviour, he then assumed it was a devil. This occurred in the case of a young man who shot himself under the chin. He initially heard voices telling him that he had a special mission to bring his extended family together and preach the word of Christ to them. When he was unable to do this successfully, the voices turned critical and told him to hurt himself. Similarly, a 17-year-old girl who jumped out of a fifth-storey window did so in response to voices which criticized her when she failed to obey earlier voices to take the microphone at a high school graduation ceremony and preach the Gospel.

In both groups, there were visions accompanying what were considered to be miracle cures. A Minnesota woman who had become deaf in her early adulthood heard the voice of Christ telling her that her hearing would be restored. A middle-aged woman with multiple sclerosis (see case no. 1 in Appendix) saw a piece of light break off from a cloud and enter her heart. She attributed her clinical remission to this event. Guibert (twelfth century) described a monk with dreadful ulcers of the hand who was cured by the appearance of St Swithin before him. The Life of St Gall by Walafrid Strabo (eighth century) described a monk who cut a vein to bleed himself (demonstrating his knowledge and practice of secular medicine) and subsequently had a swollen arm and apparently septic condition. The monk was expected to die, but had a vision of a kindly

man who told him to anoint the wound with oil from the altar. The monk did this and the swelling subsided.

There were 8 visions of Heaven and Hell from our medieval sample, comprising elaborate tours through these regions. This genre appears to be relatively culture-specific and was not described by any contemporary patients. On the other hand, 8 Minnesota patients described their visions or hallucinations as including possession experiences, a phenomenon which did not occur in any of the medieval visions, although possession is described in those times in the context of epilepsy and insanity. As we shall discuss later, the medieval description of insanity does not seem to include hallucinations, and the experience of possession, with few exceptions, is not described as occurring concurrently with or integral to a visionary state. It is possible that some of the 'possession' states alluded to in medieval sources reflects Schneiderian-type experiences of passivity and control. A young man in Minnesota described the experience that angels would speak to others through his voice. He heard his own voice say to a man that he (the patient) was just like Jesus. Another Minnesota patient felt the Devil try 'to make my hand bend over like a claw, like I was going to be a bird or something. My fingers started bending over and I said "No, I don't want to do that"'. A third patient felt that his thoughts and words were taken over by the Holy Spirit: 'I know I want to think one thing and I want to think it out loud through my mouth. And I am all frustrated because everytime I go to think and talk the thinking I want ... another thinking comes right through my spirit and right out my mouth and it's not what I want to say.'

One other phenomenon, in addition to possession, that was described by the Minnesota patients but not by the medieval sources (with one exception to be described later) was the belief, supported by hallucinatory experiences, that the person was either Jesus or designated to be the wife of Jesus. One young man who believed that he was the third person of the Trinity felt his energy flowing out like water from him to others. Another patient who believed that she was Jesus had a vision of St Anne giving her a crown of heaven.

Table 2 presents an unexpected finding, even though the psychiatric literature has commented

Table 2. Suicide and self-destructiveness

Age	Sex	Diagnosis	Act
27	M	Schizophrenia: drugs	Successful suicide by jumping off bridge
24	F	Schizophrenia	Killed 2-year-old son; shot off own leg 4 years later
17	F	Schizophrenia	Jumped from fifth-storey window; survived
26	F	Schizophrenia	Cut right hand off with power saw; hand sewn back on
22	M	Drug psychosis	Shot self in right temple at age 14, possibly before onset of psychosis
21	M	Schizophrenia	Shot jaw off with shotgun under chin
20	M	Drug psychosis	Drank bottle of kerosene
32	F	Schizophrenia; drugs	Medication overdose
23	F	Bipolar: mania	Burned 'stigmata' on hands and feet
26	M	Drug psychosis	Serious attempt to hang self

on the correlation between certain types of self-mutilation (enucleation of the eye, amputation of the hand) and delusional systems involving religious, mystical, and supernatural beliefs (Goldenberg & Sata, 1978; Tapper *et al.* 1979). There was a serious suicidal or self-destructive action in 10 of the 23 patients: 1 was a successful suicide; 3 were shot-gun injuries; 1 woman killed her 2-year-old son; 1 teenager jumped out of a fifth-storey window; and another patient cut off her right hand with a power saw in response to a vision of Henry Kissinger as the Antichrist.

In order to compare this with a base rate of self-destructiveness among patients with similar diagnoses, we reviewed all admissions ($N = 156$) during the 6-month period January–June 1981. Not including the study patients, there were 26 schizophrenic and 6 drug psychosis patients admitted to the same 24-bed ward. Three of the schizophrenic patients had taken an overdose while out of the hospital; a fourth had been transferred from a state hospital because he had tried to kill himself by jumping backwards off a radiator into his room. One of the 6 drug psychosis patients had taken an overdose and, on a different occasion, had sat with his legs dangling over the ledge of a government centre building until the police came. One teenage boy, while depressed and drunk, shot himself in the ribs. Two other depressed patients (out of a total of 34) tried to hang themselves in the ward.

Several incidents of wrist-cutting and mild overdosing occurred in the 11 borderline patients during this 6-month period (Kroll *et al.* 1981).

DISCUSSION

It is questionable whether these patients would have been considered mentally ill in the Middle Ages. An alternative explanation is that their actions would have been perceived, and possibly even respected, as acts of piety, albeit a little excessive or eccentric. There are two ways to approach this question. The first is to find reports of similar forms of behaviour in the Middle Ages and to evaluate the responses. The descriptions of visions in the Middle Ages bear a fairly close resemblance to the present reports of our patients. Several of the medieval visions we have examined consist of angels or saints chastising a person for sins of commission (wrong-doing) or omission (failure to carry out a mission). Several of our patients, including the man who shot off his jaw and the teenage girl who jumped from the window, did so in response to being chastised. The woman who cut off her right hand told a story similar to one reported by Guibert, in which a pilgrim to St James of Compostella cut off his penis in response to a vision of the Devil (posing as St James) ordering him to do this (Benton, 1970). On a more positive side, Alcuin (1954) described a vision of Willibrord's mother in which the new moon grew into the full moon and then fell swiftly from the sky into her mouth and suffused her bosom with light; this resembles the experience of the woman with multiple sclerosis who saw a piece of the sun-filled cloud break off and enter her bosom. In none of the medieval cases which we studied (including the two above) was the question of mental illness raised.

The second approach to a comparison of medieval and present-day phenomena is to find reports of alleged madness in the Middle Ages and to study the manner in which the behaviour of our patients conforms to the descriptions. There are clearly methodological hazards in such cross-temporal comparisons, not least of which is the difficulty encountered in trying to understand the *mentalité* of those whom we are studying. It is likely that experiences and verbal nuances that appear similar across cultures may have substantially different meanings and signifi-

cance. It is likely that one who believed that he was Christ in the eleventh century had a different understanding of what this encompassed from that 'same' belief in the twentieth century. However, this type of cross-cultural problem is only an exaggeration of the ordinary methodological difficulties we encounter in our present-day work. Patients tell us what they want us to know (Sacks *et al.* 1981); patients have trouble in finding words to describe their subjective experiences; and it is difficult to know when the patient says that he hears a voice whether the voice is heard inside the head, just outside the ear, louder than my voice, different from my voice, different from his own thoughts, or even whether the voice talks in the second or third person. We are also not sure that when the patient says he sees an aura around some person that what he calls an aura is what we mean by that term. Strauss (1969) has documented, in one phase of the IPSS project, the difficulty in determining the presence or absence of many of the phenomena upon which the clinical diagnosis of schizophrenia rests. In the determination of the details of a hallucination, the psychiatrist is at the mercy of the verbal report of the patient. The historian is similarly dependent on the historical record, with the limitations that the author of the medieval text is telling his readers what he wants them to know, and thus may be selective in ways we can only partially grasp.

If we were to construct a 'folk' criteria list for insanity in the Middle Ages, it would consist of forms of behaviour such as:

- losing one's wits; losing one's reason;
- babbling; refusing to speak;
- being unaware of where one is;
- wandering aimlessly;
- neglect of self, especially clothing and food;
- living wild in the forest and wearing animal skins;
- howling like a beast;
- thrashing about; raging; throwing stones at others;
- violent assaults upon others;
- biting everything to shreds;
- tearing oneself to pieces with one's own teeth.

This list of criteria is remarkably similar to those described by J. Murphy (1976) for the Eskimo and Yoruba peoples, and by Westermeyer & Wintrob (1979a) for rural Laos. Murphy states (p. 1022) that the vernacular term for

insanity in each society refers to a 'complex pattern of behavioral processes of which the hallmark is conceived to be that something inside the person – the soul, the spirit, the mind – is out of order'. Descriptions of how *nuthkavihak* (Eskimo term) is manifested include such phenomena as (p. 1022):

talking to oneself, screaming at someone who does not exist, believing that a child or husband was murdered by witchcraft when nobody else believes it, believing oneself to be an animal, refusing to eat for fear eating will kill one, refusing to talk, running away, getting lost, hiding in strange places, making strange grimaces, drinking urine, becoming strong and violent, killing dogs, and threatening people.

The Yoruba word for insanity (*were*) refers to the following phenomena (p. 1022):

hearing voices and trying to get other people to see their source though none can be seen, laughing when there is nothing to laugh at, talking all the time or not talking at all, asking oneself questions and answering them, picking up sticks and leaves for no purpose except to put them in a pile, throwing away food because it is thought to contain *juju*, tearing off one's clothes, setting fires, defecating in public and then mushing around in the feces, taking up a weapon and suddenly hitting someone with it, breaking things in a state of being stronger than normal, believing that an odor is continuously being emitted from one's body.

A notable difference between the medieval criteria and the 'folk' criteria of 3 non-industrial societies is the absence of hallucinatory phenomena in the medieval descriptions. While it is possible that the medieval descriptions lacked sufficient detail to provide such information, this explanation seems unlikely in view of the other details, including 'quotations' which are sometimes included in the sources. Rather, it appears that the medieval acceptance of a spiritual world was so complete that all 'hallucinatory' phenomena were accepted as veridical perceptions of communication with celestial and demonic persons. In fact, in the very few instances in which a person is recognized as insane and also has a vision, the vision is given full credence and is not attributed to the state of insanity or even seen as a manifestation of it.

Gregory of Tours described an episode when the saintly Abbot Aredius fell ill with dysentery (*disseneriae morbo gravari*) (Gregorii, 1951, X. 29; Gregory, 1974). On the sixth day of his

illness, a woman who had long been possessed of an unclean spirit of which Saint Martin had been unable to cure her, and whose hands were bound behind her back, began to shout to the citizens that the dead saints and martyrs were present (Ecce adest Julianus ... Privatus ... Martinus ...) for the passing of *Saint Aredius*. Her master had her tied up, but she broke her bonds and hurried off to the monastery, shouting as she went. A short time later Abbot Aredius 'breathed his last, there being considerable evidence that he was taken up by angels'. The woman was cured at the funeral of Aredius, just as the grave was closing over him (Latin X.29; English 592). It is not absolutely clear from the text that the woman actually saw the saints; however, this is the implication of her statement: 'Ecce adest' (Behold, here is).

Gregory offered a second example in which the claims (possibly, delusions) of a crazy man were dealt with at face value and were not seen as merely additional symptoms of the insanity. A man who went into the forest to cut wood was attacked by a swarm of flies and became insane for two years. He wandered through the neighbouring towns, dressed himself up in animal skins, and spent his time in prayer as if he were a religious man. The Devil was said to have given him the power of prophesying the future. The man moved on and eventually began to say that he was Christ. People flocked to him, giving him clothes and gifts of gold and silver. He laid hands on people to cure them. His following numbered greater than three thousand. Then he began to rob people he met on the road, giving all that he took to the poor and needy. He and his followers moved on to Le Puy and camped around the churches. The Bishop was fearful that he would be attacked, and sent out some of his toughest armed men to discover what all this meant. The armed men feigned obeisance to the pretender; then they seized him and killed him with their swords. The crowds dispersed. Mary, the pretender's companion, was tortured, and she told about the man's visions/hallucinations (*fantasmata*) and trickery (*prestigiae*) (Latin X.25; English 585).

The man had apparently made at least a partial recovery from his psychosis. It seems most likely that after about two years his acute and dramatic symptoms of disorganization (wandering in animal skins) subsided, leaving

him with an encapsulated delusional system and hallucinations (*fantasmata*). The text offers no information regarding the content of his hallucinations, other than the reference to his *fantasmata*. His gifts of prophecy, performance of miracle cures and, no doubt, his charismatic presence attracted an enthusiastic crowd of followers who, interestingly enough according to the text, continued to believe that he was Christ after his death. Of course, they had scriptural precedence, since his 'ministry' and death at the hands of the authorities parallel the life of Christ in many respects. Such claimants were not that unusual in the Middle Ages, especially around 1000 A.D. as the populace awaited the approach of the millennium (Cohn, 1970). It appears that, in this particular case, the man and his followers were not bothered until their movement became too socially disruptive. Indeed, his visions were accepted at face value, though attributed to possession by the Devil; and, perhaps more importantly from our point of view, no attempt was made to discredit his *fantasmata* or his claim to be Christ on the basis of his 'previous' episode of insanity. Hill & Shepherd (1976) describe a somewhat similar case of a politically active visionary occurring one thousand years later at the time of the English Civil War (1640), except that in this later case, the man, although listened to, was considered mad enough to escape major persecution. Hill & Shepherd attribute his success and survival to the very instability of the times, which tended to tolerate a greater variety of fringe zealots and revolutionaries than usual. Parenthetically, it may be noted that Gregory's 'visionary' also flourished during an episode of social dislocation, in this case caused by plague.

Very few of the 23 Minnesota patients would have met medieval 'folk' criteria for insanity. While all of these patients were hospitalized for a combination of behavioural and thought disturbances, the thought disturbances were those of content (delusional thinking) or perception (hallucinations) rather than thought disorganization. The forms of disturbed behaviour, while bizarre or highly self-destructive by our standards, were congruent with their delusions and hallucinations. Since their delusions and hallucinations would most likely have been accepted in medieval times as dramatic but not unnatural transcendental experiences, it is likely that the behaviour would have been viewed in the

same vein, and that their reports of passivity experiences, in which they felt that their thoughts and actions were being controlled, would have been interpreted as cases of possession.

The 3 case histories in the Appendix give some idea of the belief systems and behaviour of the 23 patients. For most patients the hallucinations (or visions) occurred in a state of internal excitement that was at times manifest and at times undetectable. Most were reading the Bible intensively (a few felt that it had been written just for them) and were seeing biblical parallels with many features of their lives. Six were particularly caught up in the Book of Revelation. Only one (the 17-year-old-girl who jumped out of a fifth-storey window) displayed the thought disorganization and wild assaultive behaviour that was associated with insanity in the Middle Ages. Several showed the excitement that is described as characteristic of an ecstatic state. These were recognized by their families as being in an 'abnormal' state and were admitted to hospital. However, the description of their behaviour to some extent resembles the descriptions given in Greeley's (1975) monograph of paranormal experiences in normal Americans. These experiences include feelings of passivity, as if their personality were being taken over by a more powerful being, a sense of suddenly understanding the universe, a sense of a new life, and a sense of being bathed in light. Somewhat similar descriptions are offered by people having out-of-body experiences (Twemlow *et al.* 1982). Buckley (1981) has also recently pointed out similarities between mystical experiences and schizophrenia, and Al-Issa (1977) has argued that many experiences in non-industrialized societies are similar to the hallucinations of Western schizophrenics, but that these societies focus on the social meaning of the hallucination rather than the process by which it occurs.

CONCLUSIONS

The issue of cultural relativism is a controversial one, and religious experiences raise these issues more sharply than most. The straightforward view that whichever forms of behaviour and beliefs are culturally supported must fall within the broad definitions of normality will not suffice for several reasons. Devereux (1980a) argued that the cultural relativists misunderstand the

distinction between a cultural belief and a personal experience, and that when a person incorporates a cultural belief (e.g. witchcraft) into a delusional experience (e.g. of being persecuted by witches), the experience remains delusional and the person is abnormal. Devereux (1980b, p. 215) stated: 'Indeed, for symptomatic purposes, the neurotic or the psychotic can appropriate any cultural trait – value, dogma, custom, current practice – without having to modify its external manifestations, and this to such an extent that any attempt at diagnosis becomes very hazardous.' However, Devereux offers no guidelines to make this fine distinction and, although such distinctions may be made at the bizarre ends of a continuum, it is not clear how a culture can have a belief in witchcraft without having persons believe that they are victims of it. The second problem in arguing either for or against cultural relativism is the difficulty or even arbitrariness of determining what is the majority culture and what are its beliefs. Although the twentieth century is generally considered to be an age of secularism, certainly the Christian revival movement, and especially the charismatic element, challenges such a generalization. In Minnesota a substantial number of people are taught that Christ died and returned to life 3 days later, that miracles did occur and can again, especially if the spiritual need arises, and that angels and devils exist and can make themselves known to people. The surveys of Greeley (1975) and Douglas-Smith (1971) attest that people who report mystical experiences have higher IQs and socioeconomic positions, are stable, and are not hypersuggestible.

While cultural relativism will not suffice, the arguments for culture-free symptoms remain inconclusive. Anglo-American psychiatry has justifiably been accused of psychiatric imperialism in its assumption that the symptoms of psychoses in Western industrialized countries are, in fact, the universal symptoms by which the brain disorders underlying mental illnesses express themselves. Our own evidence from medieval Europe, albeit incomplete, supports this criticism. Medieval people whose major forms of thought and behaviour disturbances were expressed in a religious mode were not considered psychotic, even when this expression included self-destructive, socially withdrawn (hermits, recluses, inclusions), visionary (hallucinatory), and heretical

features. When similar forms of religious behaviour are manifested in present-day Minnesota, the people are considered psychotic.

In regard to the search for evidence of schizophrenia in the Middle Ages, the sources examined provide many descriptions of madness, some of which appear to be descriptively similar to schizophrenia as we view it today. However, two of the major hallmarks by which schizophrenia is identified today – hallucinations, and experiences of passivity and control – appear to have so closely approximated accepted modes of medieval transcendental experiences that they were not regarded as symptoms of psychoses. This is less clear for possession states than for visions, since it is sometimes difficult to determine from the sources when a reference to 'being possessed' is just a convenient figure of speech functioning within a generally accepted world view (the reality of demon spirits) and when it refers to a specific complaint by the 'possessed' person. We are investigating this question in a separate study.

It would appear that H. B. M. Murphy *et al.*'s (1963) warning about the limited diagnostic usefulness of delusions must be echoed in regard to hallucinations, especially of a religious nature. These phenomena are too culture-bound to be universal diagnostic criteria of psychosis. It is not just 'primitive', non-Western, non-industrialized societies that provide social support for hallucinations and altered states of consciousness. The sanctioned presence of these phenomena in Western Europe during the Middle Ages and in considerable segments of contemporary Western culture calls for a reassessment of the assumed psychopathological significance of religious 'symptoms'.

APPENDIX

Case 1

A 35-year-old, single, school teacher, a devout Catholic with no history of alcohol or drug abuse, began to hear the voice of her priest while visiting her family in Minnesota. Prior to the visit from Arizona she had been under a great deal of pressure, giving emotional support to several other friends in crises. While visiting her family she became very preoccupied with studying the Bible, especially the Book of Revelation. 'It seemed like the more I read it, the more things started falling into place as to even the place of the new kingdom being in Arizona, and Babylon being

the United States, and talking about the second coming of Christ and Christ having to suffer all over again for the world, and that Christ would pick a bride to be the bride of Christ. So I started putting names to people, you know, like the new Jerusalem was going to my town in Arizona, and the special temple would be the church that I go to, and that Christ was this special friend Tom, the priest at the church, and the bride was going to be me.' While travelling from Minnesota to Iowa to visit relatives, she began hearing a voice talking to her, sometimes identified as Tom the priest and sometimes as Jesus. The voice was heard 'in the left ear' and sounded like a normal voice. Several hours later she also began hearing the voices of 'kindred spirits' in her right ear. In obedience to the priest's voice, she pulled her car over to the shoulder of the interstate highway and began preaching to the cars speeding by. 'I stopped the car, got out and yelled "Stop world, you're driving everyone crazy." And because Tom or the voice had said that the world was going to blow itself up, that somebody somewhere in the world, someone that had the power to push atomic weapons was going to blow the United States up or other parts of the world and the world was just going to destroy itself ... I was telling them to stop and look at the world to see the creation of God and the trees, the flowers, people; I just started naming all kinds of things that there were to be thankful for and I was yelling and screaming.' Her mother, with whom she was driving, persuaded her to return to the car and resume their journey. She suddenly had the feeling that the Devil was in her mother, and then in her. She was now driving in the wrong direction. 'I was just driving and then for some reason it hit me. The need to lay down my life for my friends means I have to commit suicide because I was just driving a car and just holding the wheel real tight. As soon as I said suicide, I said "No, suicide is wrong, even if it means to save the world, I cannot commit suicide because then I would be destroying myself." So then the second time I pulled off the road, kind of collected myself to see where I was at, and got myself back on the road, and turned around and headed back to town.' After arriving at her mother's house, she remained mute and immobile for 24 hours, while she was intently listening to her voices. Although in a state of great excitement with racing thoughts, she gave the appearance of being catatonic and was brought by her family, with much resistance, to the hospital.

Case 2

A 27-year-old, single, male graduate student of Catholic background was committed to the hospital by his family because he claimed that he was Jesus Christ and had to commit suicide. He had also threatened to kill either his 9-year-old niece to show

the world how much suffering is in it or a 'random abortion doctor'. He had left professional school two years previously and thought about starting a violent revolution. He burned an American flag on the altar of a church, thinking that he was Christ and that 'His' church, by flying an American flag, was supporting a government that condoned abortion. He had been a heavy user of marijuana for 3 or 4 years, apparently staying high for 8–10 hours a day. Following admission to the hospital he initially refused to cooperate, including refusal of medication. He finally agreed to take antipsychotic medication and appeared to improve, i.e. to say that he knew he was not Christ. While out on a day pass with a girlfriend, he committed suicide by jumping off a bridge after his girlfriend left him outside the hospital rather than escorting him to the ward.

Case 3

A 25-year-old, single, woman, whose father was a marginally successful Lutheran minister, was admitted to the hospital following the self-amputation of her right hand with a power saw. Two years previously the woman had been hospitalized in northern Minnesota when she tried to preach the Gospel to bystanders in bitterly cold weather while half-naked, like the 'woman in the wilderness in Revelations 12'. For 2 weeks prior to amputation, she had been in a state of internal agitation. She was seeing the face of Henry Kissinger, and at times heard his voice. One night, while staying at a friend's house but unable to sleep, she walked into the garage. There she saw the face of Kissinger as the Antichrist, telling her that unless she hurt herself, her sister and 300 other people would perish in a plane crash. She turned on the rotary power saw and lowered her wrist over it, possibly as much to test it (as one does with superficial razor cuts) as actually to take off her hand. But there was no second chance. Her wrist was 90% severed, although her hand stayed attached. It was sewn back on at a local hospital and is now partially functional 3 years later. The woman did not use alcohol or drugs. She was a very bright student who turned down a National Merit Scholarship in order to attend a local two-year Bible college. Her family thought she had been possessed by a devil at the time of the self-amputation.

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