SEMAI RESPONSE TO MENTAL ABERRATION

I INTRODUCTION [1]

This paper presents a sociological analysis of the responses to mental aberration exhibited by the Sen'oi Semai, an Austro-asiatic people of central Malaya. This introduction outlines the data and the approach taken to these data. The next section of the paper presents Semai descriptions of the nosology and etiology of mental aberrations, followed by a description of the treatment of these aberrations. The concluding section attempts to discover what dimensions of mental aberrations, as viewed by the Semai, are significant in determining the kind of treatment accorded those aberrations.

The Semai

The data reported here were collected during the years 1961-1963 under grants from the Ford Foundation and the American Museum of Natural History. The author and his wife resided in two Semai villages, one of about 150 people on the upper reaches of the Telom River in Ulu Pahang on the eastern side of the Main Range; and one of about 200 persons on the other side of the mountains, in central Perak. About seven months were spent in each village. The population figures just given are rather misleading, since the Semai frequently visit each other for long periods or shift residence from one location to another, with the result that we had the opportunity to talk to two or three times the number of people who were resident in our village at any given time.

The Semai use a simple dibble-axe-machete technology to cultivate hill rice and tapioca in swiddens. On the western slopes of the mountains which divide Malaya on a north-south axis, the Semai rotate

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[1] I am indebted to Dr. T. R. Williams, Dr. R. Kaelbling, Mr. R. P. Sprafkin and Dr. H. B. Pepinsky for reading and commenting on this paper.

Dentan, R. K. 1968. “Semai Response to Mental Aberration.” *Bijdragen tot de Taal-, Land- en Volkenkunde* 124: 135 – 158. © Koninklijk Instituut voor Taal-, Land- en Volkenkunde, Leiden, The Netherlands, which has granted permission to copy this article for the Peaceful Societies website.

their swiddens around semi-sedentary villages. In this area, they have been in fairly close contact with Malays for about three generations. In the east, villages relocate every two to four years to clear their swiddens in a new area. In this area, significant contact with the outside world did not begin until the 1950's. Political integration at the village level seems, in the east, to be a recent development and functions almost entirely to handle relations with non-Semai. In the west village structure is tending to become similar to that of the Malays.[2]

The bulk of research on mental disorders in non-Western societies has been done by psychological rather than social anthropologists. The result is that there is a relatively large body of data on the psychic aspects of mental disorder and relatively little on its sociological aspects.[3] It has been suggested that much of this data confuses sociological factors (e.g., the way informants say "madmen" behave) with psychological ones (e.g., the way they in fact behave).[4] This paucity of data is not unique to anthropologists. Sociologists also confess that relatively little is known of the diagnostic process, the norms involved in mental disorder or the preferred treatment of the aberrant behavior systems among the various subgroups of Western society.[5] The aim of this paper is therefore twofold: (1) to add to the body of data on the sociology of mental disorder and (2) to suggest ways in which such data may be analyzed.

It is perhaps worth remarking that I have observed people supposedly afflicted with all the disorders listed below except berserk, and that I had the opportunity to talk with three men who said that they had gone berserk. Observed behavior in these few instances conforms fairly closely to the Semai description, although the aberration is generally much less striking than the Semai reports would indicate. Whether or

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[2] For which, see J. M. Gullick. 1958. Indigenous political systems of western Malaya. London. Pp. 23-43.

[3] A. F. C. Wallace. 1961. Mental illness, biology and culture, *In* F. L. K. Hsu (ed.) Psychological anthropology. Homewood, Illinois.

[4] R. Kaelbling. 1961. Comparative psychopathology and psychotherapy, *Acta Psychotherapeutica* 9: 10-28.

[5] J.. A. Clausen.1959. The sociology of mental illness, *In* R. K. Merton, L. Broom and L. S. Cottrell, Jr. (eds.) Sociology today. New York.
M. B. Clinard. 1964. Contributions of sociology to understanding deviant behavior, *In* M. L. Barron (ed.) Contemporary sociology. New York. P. 617.
E. M. Lemert. 1951. Social pathology. New York. Pp. 387-88.

not people behave as the Semai say they do, however, is relatively unimportant for the purposes of this paper. What is important is that the Semai expect people with mental aberrations to perform in a certain way and treat them accordingly. To take a comparative example, it is important to know that for many Americans "mental illness" refers to violent and unpredictable behavior best treated by confinement,[6] whether or not the mentally ill actually conform to this stereotype.

II DATA

Nosology

Introduction. Following the procedure of Wallace,[7] this section is divided into subsections based on criteria which a western observer would use to categorize types of mental aberration among the Semai. Each subsection includes (1) the words used by the Semai to describe the aberrant behavior; (2) where necessary, a description of that behavior; and (3) the other contexts, if any, in which the Semai use the words that describe these behavior systems. Hopefully, this contextualization provides a clearer insight into the nuances of meaning of the Semai words than translation into English would.

Unless otherwise specified, assertions about the way people behave are taken from informants' statements. Where it seems appropriate, I have supplemented these assertions with my own observations set off from the rest of the material by parentheses.

Normality. (Informants made a series of generalizations about the way Semai usually act. Although these generalizations seem not to be subsumed under any overt and conscious concept like "normality", it seems possible to construct from them a fairly accurate picture of what the normal Semai, male or female, is supposed to be like.)

A normal person has a "cool" (healthy) body and a good appetite. His sexual activities are satisfying. After a rather randy adolescence he has settled down with a spouse whom he loves more than anything in the world but his children. It is hard to tell about his feelings, because people's thoughts are known only to themselves; but his heart, the seat of emotions, is not "difficult" (unhappy).

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[6] S. Star. 1957. The place of psychiatry in popular thinking. Paper presented at the Meeting of the American Association for Public Opinion Research, May, 1957.

[7] *Op. cit.*, pp. 284-87.

He does not bother or "make difficulties" for other people. Never does he try to make someone, even his own child, do something that person would not want to do, lest the person somehow be injured. Despite his mistrust of strangers, he would not harm one. If attacked, he would flee or spread his arms in hopes the attacker would be shamed out of his aggressive intent. To his neighbors he is sociable and generous, but he does not interfere in their affairs.

Echo-reactions. The Semai recognize an aberrant behavior system of which the most striking element is echolalia, the compulsive repetition of words *(chachau).* Echopraxia sometimes occurs in association with echolalia. This system differs from Malay *latah*[8] in that the coprolalia and sexual display associated with *latah* are classed by the Semai as a type of *papaq (q.v.,* below). Any startling event can precipitate the echo-reactions. (The commonest victims are postmenopausal women who are often also midwives.)

Chachau, a Malay loan-word, is generic for incoherent discourse, e.g., stuttering or stammering. It is different from "uncertain speech" *(chakap peq tentuq),* discourse which crosses the bounds of verbal propriety, e.g., the incoherent use of sex words during certain sorts of *papaq.* Although there is no word for speech which is the opposite of *chachau,* the Semai greet well-organized and fluent speeches with cries of "Hear!" and "Good point!" In fact, leaders in Semai society, who are almost always verbally facile, frequently number the points they wish to make and use tightly knit metaphors to illustrate them.

Intellectual impairment.[9] Mental retardates are *kalot,* a word that carries the two-fold meaning of English "dumb". (Presumably, the same term would apply also to certain psychoses, although no cases were identified or described.) The denotation of *kalot* seems to be "unable to speak". An infant or a person whose larynx has been pierced by bamboo is "dumb". By extension, anyone reluctant to speak up in public is "dumb". Informants classify about a third of their adult neighbors, including people they profess to be fond of, as "dumb" in this sense.

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[8] For which, see, e.g., F. H. G. Van Loon. 1926. Amok and lattah, *J. Abnormal and Social Psych.* 21: 434-44 and P. M. Yap. 1952. The latah reaction: its pathodynamics and nosological position, J. *Mental Sci.* 98: 515-64.

[9] For a more detailed discussion of this topic, see R. K. Dentan. 1967. The response to intellectual impairment among the Semai, *Am. J. Mental Deficiency* 71: 764-66.

On the other hand, "dumb" seems to connote "slow-witted". In this sense, "dumb" is contrasted with *cherdek,* a Malay word meaning "quick-witted" or "clever". "Clever" people can outwit Malays, usually by talking circles around them. "Clever" people can persuade others to do what they want. In the rather unforma1ized Semai political structure "clever" people can become village leaders, while "dumb" people are almost always followers.

This political situation, in turn, gives "dumb" another connotation, something like "passive" or "harmless". Non-venomous snakes and people who let others take advantage of them are "dumb".

In short, the Semai classify the dumbness of moderate intellectual impairment together with the lack of verbal facility characteristic of many people. They do, however, recognize that there is a difference between them. (Visitors to a village in which there was a man too severe1y retarded to talk, for example, would always ask questions about him and how he became "dumb".)

Berserk. During the Communist uprising in the 1950's, many western Semai men in counterinsurgency units went into a state, previously unknown to the Semai, which they called *-beel behiib. -Beel* refers to a state in which the victim's perceptions blur (e.g., "his eyes spin"), his thought processes become "uncertain" *(peq tentuq)* and his behavior unpredictable. Used by itself, the phrase *ki-beel* usually means "he is drunk". *Behiib* denotes venous or arterial blood. *-Beel behiib* might thus be translated "to be drunk on blood".

Veterans' accounts of this state are mutually very consistent. A typical account runs:

> We killed and killed and killed... The Malays would stop and go through people's pockets and take their watches. We did not think of watches. We thought only of killing. We killed and killed and killed. Wah, we were drunk on blood.

The use of an analogy with alcoholic drunkenness may be more appropriate than it appears. One man said that he had actually drunk the blood of a man he had killed. “I don't know why. It tasted sweet.”

Disorientation. "Soul loss" *(deq ruai)* is characterized by lethargy, withdrawal and fretfulness. In the severe form, the symptoms begin immediately after a sudden shock, typically a fall or loud noise, and involve continuous sobbing, moaning and fever. In the mild form, the symptoms are intermittent, less intense and begin two or three weeks after the shock. Unlike the aberrations so far described, "soul loss" is classified as a "pain" or "disease" *(nyaqniq).*

Deq means, roughly, to go or be gone away. One's "soul" *(ruai)* goes away during delirium, hallucinations or dreams. The familiars of a medical practitioner, like the victims of "soul loss", become lethargic and lackadaisical while their "souls" are gone away to serve as the practitioner's familiar spirits. Prolonged loss of "soul" is fatal, as is recurrent temporary loss of "soul".

(Dr. J. M. Bolton of the Department of Aborigines has treated several cases of "soul loss". He describes these cases as disorientation due to primary or secondary shock, often involving a previous condition of physical disability due to avitaminosis, worms, amebiasis, anemia, etc.).

Psychoses. The terminology for the remaining mental aberrations is confusing, partly because of dialect differences between eastern and western Semai and partly because of the use of Malay loan-words..

The term *yeg* seems to apply to cases of strong delusions and hallucinations. For example, a hallucinogenic plant is called *berenyeg,* "causer of *yeg".* I have no record of the use of this term in any other context. The word *papaq,* of Malay origin, is used by some speakers in much the same sense as *yeg.* Unlike *yeg,* however, *papaq* may be employed as a term of abuse. A large, hairy, ugly caterpillar said to suck the breasts of pregnant women is described as a "very bad, *papaq* thing". Some informants said that *papaq* properly applied only to cases involving aberrant sexual behavior. The word *gilaq* (from Malay *gila,* "mental aberration") is sometimes used synonymously with *yeg* or *papaq* and sometimes to describe antisocial behavior, e.g., frightening people or not sharing food. These states are described as "hurts" or "diseases" *(nyaqniq)* and differ from the aberrations already discussed in involving perception of "things that are not there".

Within the broad range of aberrant behavior covered by these three words, it is possible to abstract from informants' reports three behavior systems: (1) acute melancholia, sometimes involving systematized delusions; (2) sexual *papaq;* and (3) epileptic paranoia.

(l) Malay-speaking Semai call acute melancholia *sasau,* from Malay *sasar,* "depressed" or "upset". (Mild melancholia seems to be quite common, the usual precipitating cause being the loss of a beloved person. In one observed case, a boy had known a girl only a week. On her leaving, however, he developed the symptoms supposed to characterize *sasau:* anorexia, lethargy, constant sleeping, vivid wish fulfillment dreams of being with the departed girl.)

If the loss has been great the symptoms of mild melancholia worsen. The victim becomes absent-minded, and the quality of his or her work deteriorates. He begins to hear voices, "as if he had a telephone". Eventually, he spends most of his time sitting in a corner, weeping or moaning and refusing to speak. There may be sporadic spells of restlessness or violent activity, e.g., "spinning like a top" or fleeing into the rainforest. The sufferer may accuse others of plotting against him or having done away with his beloved.

In a development from this stage, the sufferer may come to believe that the beloved person is still present. He adjusts his life accordingly, cooking for his imaginary companions, talking to them, etc. (For example, one woman carries an empty coca cola bottle around in a sling, as one carries a child, and sometimes presses her nipple to the mouth of the bottle, giving it suck.) People with such delusions tend to withdraw from an active social life, although they occasionally visit their neighbors. They never make any trouble for other people.

I have no record of the word *sasau* being used in other contexts.

(2) When people talk about *papaq*, they usually begin by describing aberrant sexual behavior. A certain type of dream, *yaiyah,* is associated with sexual *papaq*. The dream content may involve incubi or succubi, often people with whom sexual intercourse is defined as incestuous. Dreams of deer or snakes in or under one's house may also be *yaiyah.* Nocturnal emissions are evidence of *yaiyah.*

The characteristic behavior of the sexually *papaq* is the deliberate and provocative exposure of the genitalia, the one part of the body the Semai always keep covered. The victim may also toy with his (more usually her) genitals or urge others to do so. At night they sneak up on sleeping people and pull up the sleepers' clothes to expose their genitals.

Like other types of psychoses, sexual papaq is intermittent and varies with the phases of the moon. Like the melancholic, the victim tends to speak very little. When he does speak, he often uses improper words which refer to the genitals.

When, in a quarrel, one person calls another *papaq,* he is usually referring to sexual *papaq.* A man may, however, refer to his infatuation with a girl as *papaq,* much as an American might say, "I'm crazy about her". Masturbation would be taken as a sign of *papaq*, but transvestism (one reported case) and homosexuality (occurrence denied) would not be so classed.

(3) The behavior system involving loss of consciousness, falling and

clonus is called *nyelep,* a word used in no other context. The unconsciousness itself, like the unconsciousness of trance, is called "death", and grand mal epilepsy may be referred to as "die-live *disease"(nyaqniq dat suui).* An epileptic seizure begins with dizziness ("spinning eyes"), followed by nausea and fainting. While unconscious, the epileptic begins to eat things, e.g., leaves or cloth. Grand mal epileptics are usually severely scarred ("their body is no good") as a result of falling into fires, thoms, etc. Their life expectancy is short. They tend to be "dumb" *(kalot).*

Epileptics tend sporadically to attack other people. These violent episodes, which usually follow a grand mal seizure, occur "two or three times" a month. The victim begins by staring fixedly at a certain person. Shortly thereafter, he grabs a weapon — spear, machete, fire wood — and rushes at his intended victim, screaming, "I hit, I hit, I hit!" He may think that other people or he himself are ruminants — goats, deer, gaur, elephant. Eastern Semai say that epileptics try to fling themselves into rivers and streams.

(The one epileptic observed, though consistently more aggressive than other people in his village, was far from as aggressive as this description suggests.)

Etiology

Introduction. As in the previous section, assertions about etiology are based on Semai statements, with direct observations confined to parentheses. This section summarizes Semai speculations about the etiology of the disorders described in the preceding section. The discussion of this etiology is organized as follows: (1) general treatment of etiological notions; (2) diagnostic dreams; (3) actions of the patient which may have brought on the aberrancy.

In general, for the Semai there is no hard-and-fast etiology for any disorder. Causation must be determined empirically in each case, by examination of the patient, collecting of the events immediately preceding the attack, analysing dreams, testing out cures, etc. In any case several factors may be involved, and it is unwise to rule out any possibility. Nevertheless, certain types of causes are likely to be involved in certain kinds of disorder.

An important concept in Semai theorizing is *nyaniq* or *janiq,* a word cognate with *nyaqniq* (sickness, pain). The denotation is, roughly, supernatural disease-producing entity. Many spirits and certain kinds

of animals are *nyaniq*. There are two main ways in which *nyaniq* operate. The first is by capturing some intangible part of a person's being, usually the "soul", and destroying it, typically by eating it. The second is by actually entering the victim's body and destroying it from within. In the latter case, the *nyaniq* is definitely a tangible, physical entity; in the former, it is more like a spirit. *Nyaniq* are not always clearly singular or plural. When a Semai says, e.g., *nyaniq jehuuq*, he may mean "The Tree Spirit" or "tree spirits". Asked how many entities were involved, informants almost always had to pause and think the matter through before answering.

Echo-reactions. There does not seem to be any generally shared opinion about the origin of echo-reactions. The question seems not to arise. When I pointed out that all the people in one village who were *chachau* were also midwives, an informant denied that they were midwives because of their aberration; but, he speculated, perhaps the echo-reactions might be due to their being midwives, since midwifery involves communication with supernatural entities. (The correlation is not universal, however).

There are no diagnostic dreams nor do actions of the patient predispose him to suffer echo-reactions.

Intellectual impairment. Moderate intellectual impairment is part of what the eastern Semai call one's *mendoi*. *Mendoi*, from *-bedoi*, "speak", literally means "way of speaking" but is apparently also used as the western Semai use the Malay word *budi*, i.e., in the sense of "the way one is". The word is morally neutral, e.g., one says, "Ngah doesn't have a bad heart, it's just his *mendoi"*. The one case of severe intellectual impairment that we observed was attributed to a high prolonged fever (quite possibly a correct diagnosis, perhaps of cerebral malaria).

There are no diagnostic dreams nor does one become "dumb" in this sense as the result of any of one's actions.

Berserk. Berserk ultimately stems from a "difficult heart" caused by the sight of the slaughter of the people one loves at the hands of Communist guerrillas. The "difficult heart" leads to anger. Taken out of Semai society and told to kill, one is overcome by "blood drunkenness".

There are no diagnostic dreams nor does one become "berserk" because of any improper action in the past. No one would go berserk in traditional Semai society.

Disorientation. To understand the etiology of "soul loss", some understanding of the Semai notion of "soul" is necessary. The "soul" is in some ways like a child, in some ways like a bird and in some ways like a homunculus. It is birdlike in that it can cover great distances without effort, as evidenced by the perception of far-off places in dreams. It is childlike in that it is easily frightened, as evidenced by the fact that "soul loss" results from a startling event and afflicts mostly children. Finally, it is like a homunculus in that it experiences dreams as a person experiences life, yet is small enough to fit into the forehead. Therefore, to dream of killing a bird implies that someone's "soul" is in danger, probably that of a child, whose "soul" will fly away like a bird.

"Soul loss" is commoner among children than among adults because (1) children's "souls" and hearts are not yet "tough" and (2) the "soul" of a child is even more timid than the "soul" of an adult. The longer a "soul" is gone from its body, the more likely it is to come under the influence of *nyaniq.* Since this danger attaches to severe cases of "soul loss" only, the close temporal connection between the startling event and the onset of symptoms makes it possible to recognize the danger early. The noises made by the victim may be diagnostic of the *nyaniq* involved, e.g., gurgling noises suggest a water *nyaniq.* Mild cases of "soul loss" are harder to recognize, because of the longer time lapse between the startling event and the onset of symptoms.

The dreams of co-villagers and kinsmen are clues to the state of "soul loss". Besides dreams of birds, dreams of going somewhere and not arriving indicate "soul loss". The victim himself does not dream, because the "soul", which is the agent of dreams, is gone.

(Several informants asserted, however, that they had had nightmares during bouts of "soul loss". I am inclined to agree with the opinion of Kaelbling, expressed in a personal communication, that "soul loss" is a state of depression and that the shock that supposedly precedes "soul loss" involves retrospective falsification. Many of the shocks cited, e.g., frog and bird calls, occur nightly without producing "soul loss". Most of the cases we observed seemed to involve anemia, perhaps due to heavy infestation with intestinal parasites.)

"Psychoses". In general, eating certain plants can cause "psychoses". Hallucinogenic plants, improperly cooked, cause *yeg.* Other plants have fragrant flowers, which tend to attract "souls"; these plants themselves are said to have "souls" which are *nyaniq* succubi. Finally, certain

plants with red sap (e.g., *Dyera* app.) are the haunts of *nyaniq.* The psychosis stemming from eating food from such plants, however, is usually transient.

(l) Like berserk, melancholia begins with a "difficult" heart, caused by the desertion or death of a loved person. If this situation continues, a *nyaniq* finally enters the heart, "like a shadow". There are no diagnostic dreams, nor is any action of the victim responsible for the onset of the disorder.

(2) Sexual *papaq* is connected with *semelit. Semelit* is an important sort of *nyaniq* which invades the body. Although in dreams it takes the form of an incubus or succubus, in the body it is neither localized nor does it have any form. In some ways, it is like the absence of resistance to disease; "it invites the disease in". The particular disease involved may be the product of other *nyaniq*. *Semelit* diseases mainly affect the glands and/or genitals: e.g., inguinal hernia, vaginal prolapse, filiariasis (especially of the genitals), inflammation of the lymph glands or vessels, yaws, syphilis and the withdrawal of the genitals into the body. *Semelit* may give rise to *yaiyah* dreams and thus ultimately to *papaq* without the victim's having committed any offense.

Sexual *papaq* may also be due to situational factors. For example, in the absence of one's spouse one may have *yaiyah* dreams, perhaps involving incubi or succubi (i.e., *semelit). Papaq* may ensue if the separation continues long thereafter. Similarly, menstruating and, to a lesser degree, pregnant women are more likely than most to become *papaq.* Eating foods like monkey, for example, is dangerous at this time and may lead to *yaiyah.*

The commonest cause of sexual *papaq,* however, involves incestuous desires or actions, which, in turn, may be the product of *nyaniq* and/or "bad heart".

(3) Epilepsy is congenital. The usual cause is the parents' eating certain "dangerous" *(pilaq)* foods during pregnancy, notably ruminants, gibbon, argus pheasant, red-eye pheasant or a red crested ground bird called *huhaa.* It may also be due to the pregnant woman's having crossed an area where domestic animals have been killed. Eastern Semai say that water *nyaniq* may also be involved, as evidenced by the alleged hydrotropism of the epileptic. Western Semai are inclined to implicate the gibbon-like tree *nyaniq,* as in any condition that involves falling or dreams of falling. If these *nyaniq* actually enter the victim, the resulting seizure will be fatal.

The aggressive behavior of the epileptic is due not merely to these factors but also to his having a "bad heart".

Pilaq disorders usually do not involve dreams. Nevertheless, dreams of the mammals listed above may be diagnostic of the fatal seizure. As already noted, it is the activities of the parents rather than of the victim which cause the attacks.

Treatment

Introduction. Most of the following section is based on personal observation. I have tried to make clear which information comes from informants by using words like "should", "prescriptively", etc.

Primary responsibility for supportive and medical care is vested in the victim's consanguineal kinsmen, with affines and co-villagers taking secondary responsibility. People talk as if the main reason for assuming these responsibilities is sentimental. That is, one cares for the patient because one is or has been fond of him. Moral factors play a distinctly minor role. A person who dodges this responsibility might be the butt of malicious gossip, but only from people who for other reasons disliked him. Similarly, the person who does assume the responsibility may be said to have acted properly, should the question arise, but his action would probably not be cited in a discussion of his character. Obviously, there is no jural assignment of responsibility. In general, this pattern fits Semai notions of proper behavior, *viz.,* that interference by word or deed in another's affairs is bootless or even harmful.

It is worth sketching the two major ways in which the Semai medicate mental aberration (and diseases). The first is the "sing", a ceremony which takes place on two successive nights (six, if the first "sing" is unsuccessful), with all fires extinguished. The women pound bamboo stampers rhythmically against a log, while both men and women sing. A magico-medical expert (or experts) invokes his familiar spirit(s) to aid him in diagnosing and treating the disorder. These familiar spirits are attracted by the presence of fragrant plants, "spirit perches" and sometimes other gifts. During the ceremony the expert or the younger men go into trance. Some informants said the trance was due to possession by familiars, others that the "soul" of the person in trance has gone into the rainforest to seek the familiars whose own "souls" are attending the sing. Besides the patient for whom the sing was originally called, two or three other people take the opportunity to get medical attention.

Within the village population, the consanguineal kinsmen of the

patient usually attend. In the east, almost everyone in the village attends. I believe that there are two main reasons that more people and a larger proportion of the village population attend sings in the east than in the west. First, other entertainments are rare in the east, and sings may be held simply for the fun of it; while in the west coffee shops, radios and movies provide alternative entertainments, and sings are almost never held for fun. Second, in the west, under the impact of a money economy, the effective unit of production and distribution is smaller than in the east, with the result that fewer people in the west have a direct economic interest in curing the patient. Unfortunately, space does not permit an expansion of this argument.

For all the bewildering stylistic variations between sings, the central purpose remains the same, viz., to effect a cure by extracting (through sucking and/or palpation) or expelling (by prayer, curse and invocation) a malignant entity, almost always a *nyaniq*.

Spells *(jenampiq,* from Malay *jampi),* many of which are in Malay, constitute the second major method of curing. If someone in the village knows the appropriate spell, he may recite it in addition to, during, or instead of a sing. Usually, however, treatment by spells, which requires the presence of only the patient and the spell-sayer, precedes treatment by sing, which requires a larger number of participants. People are vague about how spells work but, e.g., suggest that in cases of "soul loss", spells "call the soul back", whereas familiar spirits go and get the "soul".

No fee is required for medical attention, although some gift is considered proper. Traditional Semai economy is based on "multi-person" reciprocity, i.e., a donor gets back the equivalent of what he has given not from the recipient but from some other party or parties. The rationale seems to be that, as the medical expert has helped out in this case, so someone else will help him out when he is in trouble. The exception to this rule is that, if the patient dies, his relatives are bound to perform a ceremony that will restore the "salt" of the medical expert which has thus been lost.

Echo-reactions. There is no medical treatment for echo-reactions. Afflicted persons can manage any routine Semai activity and may succeed in such specialized pursuits as midwifery. People sometimes try to startle them in an attempt to set off the echo-reactions, but no one expresses any feeling against associating with them or marrying them. There is no more provision for their support than for the support of everyone else.

Intellectual impairment. There is no medical treatment for intellectual impairment. A mild retardate can perform most routine activities, though he will excel at none. People sometimes tease or mock retardates, as they would anyone with an amusing personal idiosyncrasy like a shrill giggle, a squeaky voice, blind eyes, etc. No one seeks or avoids the company of a retardate. No one would marry a retardate.

In rather more severe cases of intellectual impairment, the victim is dependent on the goodwill of some consanguineal kinsman who is willing to take him in. He does the simpler jobs around the house, like gathering firewood and pounding grain. In times of scarcity he receives inferior goods, e.g., raged clothes, manioc instead of rice. Otherwise, although his housemates may speak to him gruffly or laugh at him, he is a full member of the household. Both inside and outside the household, people recognize that his intellectual incompetence excuses behavior that would be intolerable in other people. For example, one severely retarded eastern Semai man killed a household chicken while trying to shoo it out of the house a major economic loss to the family, since selling chickens is the main way the eastern Semai can get goods from the outside world, like metal, salt and cloth. In most cases, the accident would have led to bitter recrimination and complaint, but, said the head of the household, "What can you do? He's dumb". The women of the village let the same man bathe with them, although men and women prescriptively bathe separately. "He's dumb", they explained.

Berserk. Since episodes of berserk occur only outside Semai society, there is no medical treatment. The returned veterans are completely accepted members of Semai society, able to marry and to perform any routine activity. They speak of their experience calmly and freely, with no overt emotion except a mild and not altogether displeased astonishment that they should ever have acted in such a way. They purse their lips, shake their heads and finish by saying, "Drunk on blood" or "I don't understand it". If the audience has not heard the story before, they may exclaim "Wah!" or pat their chests with surprise, but again there seems to he little overt emotional involvement and certainly no moral condemnation.

Disorientation. A diagnosis of "soul loss" leads, with as little delay as possible, to a sing and spell-saying. During the sing, the patient is bathed with decoction of fragrant plants and flowers to make him "cool" (i.e., healthy) and to render him attractive to his departed

"soul". The medical expert, with occasional help from the audience, cajoles the bird-like "soul" to enter the "spirit perch", chirping to it as one calls a chick to come and be fed. The spell is delivered to the top of the forehead, where the "soul" normally resides. Medical treatment continues, prescriptively and in fact, until the patient mends or dies. If the local medical experts consent, English, Malay and/or Chinese medical experts may be consulted.

Sufferers withdraw from routine activities, and people make a special effort not to bother them lest the affliction worsen. Teasing them or laughing at them would be "not good". Marriage is out of the question while the symptoms persist, simply because the patient is unable to make the effort required. On the other hand, "soul loss" wouldn't lead, informants said, to separation, nor would a history of "soul loss" make a person a poor choice as a spouse. Since the victim is usually a child, the problem rarely arises. Supportive care is usually the responsibility of the child's parents and midwife.

Psychoses. Psychosis is prescriptively and in fact treated by sing and spell, but without the urgency that attaches to "soul loss". One should, informants said, be pleasant and soft-spoken with psychotics, lest their affliction worsen. Teasing them is therefore wrong, although people may smile or chuckle when describing their behavior. In fact, however, people tend to follow these rules strictly only with melancholies. Sexual *papaq* provokes a disgust not readily concealed. People, especially children, mock and tease epileptics with a deliberate brutality and overt hostility quite uncharacteristic of normal Semai behavior. In general, people avoid initiating social contacts with psychotics; but, since interference with another's actions is improper behavior, they permit psychotics to visit and talk with them.

(1) The initial stages of melancholia usually go untreated, although people are less likely to ask the victim's help in any activity. The melancholic himself should avoid pulling a sarong over his head or walking under clothes hung out to dry. People were unable to explain these restrictions, although they may be connected with the notion that the "soul" resides in the forehead. On the other hand, walking under clothes hung out to dry is said to be dangerous in other parts of southeast Asia. The acute phases of melancholia are prescriptively treated by sings and spells. If the patient shows no signs of improvement, people eventually give up trying to help him, especially if he has systematic delusions that seem to make him happy.

The patient's ability to perform economic activities is somewhat impaired, but, again especially in a case of systematic delusions, he may remain self supporting. Social activities usually dwindle to a minimum: Melancholia may or may not lead to divorce, and no one would marry an acute melancholic.

People with systematic delusions should not be contradicted or "made difficulties for" in any way, lest their symptoms grow more pronounced. In one observed case, reportedly fairly typical, a woman refused to acknowledge her husband's desertion. She refused all aid from her co-villagers and consanguines on the grounds that her husband took care of her. She lived in a house she had built without help, supporting herself by the sale of wild banana leaves to a Chinese who used them to wrap food. When she ran short of food, she reportedly stole it from her co-villagers' swiddens rather than imply her husband was not supporting her. People's response to these thefts was good-humored: "If she asked for it, we'd give it to her. It doesn't matter. She's *yeg"*. One man told of how she had refused a gift of money from him on two occasions, saying that with her gunnysacks of rice, her husband and her child (all imaginary) her heart was happy. The informant paused for a moment, smiled and said, "Maybe she's right". After a few sings and an unsuccessful attempt to persuade her to go to the government mental hospital, people had stopped trying to cure her.

(2) If a person has *yaiyah* dreams and/or nocturnal emissions, he should at once describe the situation to his spouse. Their discussion, if all goes well, will shame the *nyaniq* into abandoning its lascivious attentions to the victim.

Full-fledged sexual *papaq* is prescriptively treated by sing and spell, but in this case people reportedly keep trying to effect a cure. Although the sufferer's economic activities are only slightly impaired, his social life suffers as people tend to avoid or ignore him. No one would attempt to elicit the symptoms, and, although some people chuckle when describing this behavior system, others shake their heads and say "not good". People say that they would be "afraid" to marry the sexually *papaq*, although in two observed cases a husband continued to live with his *papaq* wife. Only close kinsmen will undertake day-to-day responsibility for the sexually *papaq*. After a few incidents of *papaq* behavior, there is likely to be an exodus of members from the victim's household. In the cases we observed, the patients' clothes were more ragged than those of their housemates, and people rarely addressed

them or paid them any other attention except to feed them. Reportedly, in extreme cases, co-villagers of the sexually *papaq* will tie their doors shut at night to avoid being molested in their sleep.

(3) Informants said that epilepsy, being congenital, must be treated in its early stages if a cure is to be achieved. The epileptic's economic activities are sporadically disrupted by seizures, and his social life is disrupted to a great extent for several reasons.

First, the aggressiveness of the behavior which the Semai associate with epilepsy is socially intolerable even if it stops short of physical violence. As a child, the epileptic is avoided or tormented by his playmates. His "paranoid" and/or violent responses to this treatment, in turn, lead to further ostracism. Adults will alternately tease and reject him until he is big enough to be potentially dangerous. Everyone fears him and lets him know it. The behavior system that emerges from this experience, coupled with the original organic disorder, is obviously going to be abnormal. Second, an epileptic Semai child makes his own parents nervous, with the result that they may be covertly hostile to him and treat him very severely. Epileptic children are, apparently, dressed more poorly than other children in the same family. Third, epileptics are usually badly scarred as a result of falling into fires, thorns, etc. The fact that they look ugly tends further to disrupt their social life. As a result of these factors, the initial biogenic disorder is exacerbated by social experiences.

People avoid epileptics whenever possible. They will bluntly refuse an epileptic permission to enter their houses (a refusal which otherwise would occur only in the context of a bitter quarrel), although, if the victim ignores the rebuff and enters anyway, they will simply ignore him or tell him to "go home". Malicious teasing of an epileptic child by his age mates is common as long as the victim does not respond with physical violence.[10] Should he become violent, people say that they would flee and/or tie their doors shut against him. Prescribed behavior is to confront the would-be violent epileptic and dare him to strike one, so as to scare and shame him out of his purpose. Alternatively, his close consanguines and their friends would be justified in tying him up until his seizure had passed.

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[10] Adult Semai teasing of people with mental or physical peculiarities is ostensibly in a spirit of good fun, with the butt expected to laugh. Adults, however, rarely interfere with children's activities. The only instance in which I saw an adult rebuke children for maliciously teasing an epileptic boy involved an extremely kindly woman, who said that the boy's scarred face and body were not ugly. "Why, if I were younger", she said, "I'd marry him myself".

The responsibility for supporting an epileptic devolves on his natal nuclear family, marriage being out of the question. This support is given grudgingly. Although Semai parents are usually reluctant to let their children out of their own care, the parents of the epileptic boy whom we observed were willing to send him anywhere to be cured.

Conclusion. An interesting point implicit in the above discussion is that many of the attitudes that the Semai express towards their fellows are those prescriptively held in Euro-American societies by the custodial staff of mental hospitals. The results of the Semai emphasis on the autonomy of the individual and on "not making difficulties" for people are rather like the results of the training Euro-American custodians receive. Like a custodian, a Semai should regard his fellows dispassionately, but with interest and some understanding, providing for their biological needs when necessary, leaving them to act as they will unless they become violent and require restraint.

Such a set of attitudes is incompatible with day-to-day life in Euro-American society, with the result that the mentally aberrant are incarcerated among trained personnel, for their own sakes and for the sake of the orderly continuity of daily social relations. In Semai society, the provision of custodial care does not require so sharp a wrench from ordinary patterns of interaction, nor, except in extreme cases, does mental aberration significantly affect the form of social relations, although it may affect their frequency. Perhaps as a result, the Semai apparently do not usually incarcerate or otherwise expel the mentally aberrant.

III ANALYSIS

Introduction

To explicate the factors that condition the Semai response to mental aberration, I have made use of three conceptual schemes. When the data on nosology (and in some cases etiology) are arranged in terms of the presence or absence of the factors that one of these three authors considers significant, then one should be able to predict that a specific sort of treatment (and in some cases etiology) will be present if a given factor is present and absent if that factor is absent. This procedure is thus something like componential analysis.

The aim of this section is to determine which of the three conceptual schemes most adequately accounts for the Semai data. It should be

emphasized that the focus of this analysis is on the usefulness of these schemes in coming to understand the available Semai data, not data on the Semai which are yet unknown nor data on other peoples. Neither the usefulness of these schemes in other areas nor their theoretical basis is in question. On the other hand, a thoroughly adequate scheme should account for the Semai data as well as others.

Wallace's Approach

Typology. In a stimulating article that covers a much broader area, Wallace[11] suggests classifying data on mental aberration according to. two dichotomous dimensions to be determined by the observer: *viz.,* mild *vs.* severe aberration and intermittent *vs.* continuous aberration. The resulting categories may be compared with those formed by two other dichotomous dimensions: *viz.,* whether the society "extrudes" (e.g., confines, expels, kills) the deviant or "treats" (e.g., ignores, medicates) him; and whether people regard the aberrant behavior as a transitory lapse ("episodic") or as a manifestation of an underlying and continuing disorder ("symptomatic"). Finally, Wallace hypothesizes that technologically primitive, small scale societies like the Semai will (1) classify intermittent disorders as "episodic" and continuous disorders as "symptomatic" and (2) will "extrude" deviants only when the aberrant behavior is both severe and continuous.

The Semai data may thus be grouped as in Figures 1 and 2.

	Intermittent	*Continuous*
Mild	Echo-reactions	Feeble-mindedness Mild melancholia
Severe	Berserk Psychoses other than melancholic delusions	"Soul loss" disorientation Severe mental retardation Melancholic delusions

Fig. 1. Severity and chronicity of disorders (author's estimate).

[11] *Op. cit.,* pp. 283-87.

	*Symptomatic**	*Episodic*
Treated	Mental retardation "Soul loss" disorientation Psychosis	Berserk Echo-reactions
Extruded		

Fig. 2. Semai response to mental disorders.

* Disorders are classed as "symptomatic" if they involve *nyaniq* or *mendoi.*

Implications. As Wallace[12] notes, all four dimensions are continua, with the result that there is some difficulty in assigning certain "borderline" disorders to one cell or another. For example, in Fig. 1, most psychoses are classified as "intermittent" because informants report that (1) they vary with the phases of the moon and (2) temporary or permanent remission of symptoms may occur. A case could be made, however, for calling all psychoses "continuous". Similarly, "soul loss" is, as a period of uninterrupted dysfunction, continuous; but, since recovery may be followed by relapse, perhaps it should be classified as intermittent in some cases.

Despite similar difficulties of classification, Fig. 2 seems to support neither of Wallace's hypotheses. Conceivably, reluctance to initiate interaction with a psychotic is "mild extrusion" but even the psychotic is economically and, to some extent, socially a functioning member of Semai society. True "extrusian" in the form of confining the victim is reported only for the most violent cases of epileptic paranoia. Possibly, however, the absence of data on extrusion is misleading. Although informants, with a couple of exceptions, deny that the Semai ever "extrude" deviants, there is some evidence that, in times of economic hardship before government medical assistance was available, the victim of total, incurable physical disability might be abandoned in a leanto with a small supply of food and water. The only evidence that such extrusion might have occurred in the case of mental aberration is negative. Eastern Semai diet is generally deficient in iodine, a situation which might, if the deficiency were total, lead to cretinism.

[12] *Ibid.,* 284-85.

No cases of cretinism have been reported or observed.[13] Possibly cretins are "extruded". On the other hand, equally possible, cretins, catatonics, etc., may simply die because of the Semai reluctance to force anybody to do anything (e.g., eat), without being "extruded".

The only obvious correlation between the Semai data and the Wallace scheme is that victims of "episodic" derangement are considered marriageable, while victims of "symptomatic" aberration are not.

Conclusion. Although this scheme does suggest areas for future research, it does not significantly clarify one's understanding of the Semai data, perhaps because of the difficulty of applying Wallace's categories to the data.

Merton's Approach

Typology. Merton[14] classifies modes of adaptation to society in terms of the acceptance or rejection of culturally defined goals and of institutionalized means for reaching those goals. In terms of this scheme, echo-reactions, mental retardation, berserk and "soul loss" disorientation are egoistic in the sense that they do not occur in relation to any specific goal or set of goals. Echo-reactions do not affect the victim's relationship to cultural goals and means. Mental retardation and "soul loss" disorientation seriously interfere with the victim's ability to attain the cultural ends in the proper way, but acceptance or rejection of these goals and means is not in question. Berserk occurs outside the society in which the goals and means obtain.

The psychoses, on the other hand, do involve goals and means. In fact, the genesis of melancholia seems often to lie in the strong internalization of a cultural goal (a happy family life with spouse and children) coupled with a situation in which the institutionalized means are not sufficient to allow reaching that goal. The delusions that resolve melancholia are, in a sense, a statement to oneself that one *has* obtained the cultural goal; they thus serve as a non-institutionalized means for doing so. In the other psychoses, cultural goals are flouted and impremissable means of obtaining forbidden satisfactions come publically into play.

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[13] See, e.g., I. Polunin. 1953. The medical natural history of Malayan aborigines, *Medical J. M alaya* 8: 55-174.

[14] R. K. Merton. 1957. Social theory and social structure. Rev. ed., Glencoe. Pp. 140-163.

Implications. Examining the data in this way suggests the following possible interpretations. (1) The psychoses are classified together, and the symptoms of one syndrome are sometimes appended by informants to the symptoms of another, because all psychoses involve disabilities in the same area *(viz.,* cultural goals and institutionalized means). (2) The attitude toward melancholia, especially melancholic delusions, is less harsh than the attitude towards the other psychoses, because, unlike the other psychoses, the melancholias do not involve rejection of cultural goals. (3) Other mental aberrations are regarded as distinct from psychoses because they are egoistic with respect to any given set of goals or means; for the same reason, they are not condemned. (4) These non-psychotic aberrations do not fall into a single type for the Semai, however, because all they have in common is the negative factors of not being psychoses.

Lemert's Approach

Typology. Lemert[15] stresses that the social response to deviance depends on whether the deviance is classed as an individual and/or social problem. Again there are two dichotomous dimensions: individual, problem/not problem; social, problem/not problem.

Analyzing their own responses to aberrant behavior systems, informants explicitly referred to whether or not the deviant "made difficulties for other people". Making difficulties for other people seems to mean involving them against their will in one's own aberrant behavior. "Making difficulties" may thus be taken as indicating that the behavior is a social problem. The presence of "pain" *(nyaqniq)* and/or "pain-causing agents" *(nyaniq)* may be taken as diagnostic of individual problems. The resulting distribution is similar to that along Wallace's symptomatic/episodic dimension, as Fig. 3 indicates.

		Individual Problem	
		Nyaniq	No Nyaniq
Social Problem	Yes	Sexual *papaq* Epileptic paranoia	
	No	Acute melancholia "Soul loss" disorientation	Mental retardation Echo- reactions Berserk

Fig. 3.

[15] *op. cit.,* pp. 32-33.

The dassification of berserk as a non-problematic state may seem frivolous. In fact, however, people seem to regard "blood drunkenness" as "episodic" in Wallace's[16] sense, *i.e.*, "as an isolated episode in an essentially normal life program". Having gone berserk is thus not an individual problem and does not occur within the confines of *Semai* society *(cf.* American attitudes towards the behavior of American soldiers on foreign battlefields). Its not being a social problem in turn makes it easier for the individual to dissociate an episode of "blood drunkenness" from his normal life.

Implications. This sort of classification, which corresponds fairly closely with explicit Semai statements, suggests several possible interpretations of the Semai response to mental aberration. (1) Non-problematic behavior systems get no medical treatment (i.e., echo-reactions, berserk, mental retardation). (2) Notions of etiology seem to be, for the Semai, means of coming to grips with a problem intellectually as prelude to or rationalization of dealing with it on a practical level. Since no problem is involved and no action is contemplated, there is no need for a complex etiology for non-problematic aberrancy. For example, no non-material entity need be hypothesized to account for these states. (3) Even if *nyaniq* are involved in a behavior system, when the system seems satisfying for an individual and provided that no social problems ensue, then there is a tendency to stop attempting medical treatment, *e.g.*, after melancholia has been resolved by systematic delusions. (4) There is no need to mark off unproblematic behavior systems linguistically as categorically different from "normal" behavior, because no one has to deal with (and thus identify) them as problems. Thus severe mental retardation is only extreme "dumbness", echo-reactions an idiosyncratic sort of "stammer" and even berserk only a weird sort of "drunkeness". (5) Attitudes towards the victims of non-problematic disorders seem similarly akin to attitudes held towards those suffering from a less acute form of "the same thing" : *viz.*, amusement, patience and contempt for the "dumb"; amusement for the "stammerer" ; and bewilderment and curiosity about the "drunk". (6) As long as no interference with others is involved, mental aberration which makes a person suffer appears to be regarded with compassion or indifference rather than condemnation. (7) There is therefore no marked tendency to avoid the victim, although he or she may

[16] *Op. cit.*, pp. 284.

be ignored. (8) In such cases, however, since a medical attempt to aid the victim should be made, a more complex etiology is required *(cf.* 2 above. (9) Interference with other people runs so counter to "normality" that it must be due to abnormal, unnatural entities, *i.e. nyaniq.* Hence, there is no socially problematic mental disorder not attributed to *nyaniq.* (10) Such behavior is, as already noted, condemnable as a denial of the value of cultural goals and institutionalized means. This condemnation is reflected in an etiology peculiar to these cases, *viz.,* that the onset of the aberration may be due to some transgression on the part of the victim or a close associate.

IV SUMMARY AND CONCLUSIONS

This paper has presented a body of data on the Semai pattern of response to behavior systems that a Westerner recognizes as the product of "mental illness". These data were fitted into categories according to three conceptual schemes in an attempt to see which of these schemes was most useful in elucidating the data.

In this case, Lemert's approach seems to be the most fruitful, at least in part because Lemert's criteria for types of deviance apparently correspond fairly close to the verbalized opinions of Semai informants. Conceivably, however, other approaches might be more useful in dealing with the sociology of mental illness in other societies. Similarly, the interpretations suggested by these various approaches may be appropriate only in the Semai context or may have a wider crosscultural applicability. At present, anthropology needs more intensive studies in the sociology of mental illness before it is possible to arrive at categories which are simultaneously abstract enough and relevant enough to permit meaningful cross-cultural studies to be made.

R. K. DENTAN

Ohio State University