"Holy dwarves" and "devil babies": An anthropological world-survey of stigmatization of the disabled

Tommi Louise White
University of Nevada, Las Vegas

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“HOLY DWARVES” AND “DEVIL BABIES”:
AN ANTHROPOLOGICAL WORLD-SURVEY
OF STIGMATIZATION OF
THE DISABLED

by

Tommi L. White

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ABSTRACT

"Holy Dwarves" and "Devil Babies": An Anthropological World-Survey of Stigmatization of the Disabled

by

Tommi L. White

Dr. W. Jankowiak, Examination Committee Chair
Professor of Anthropology
University of Nevada, Las Vegas

Disability exists as a human universal based upon conceptual categorizations. Positive and negative forms of stigmatization exist cross-culturally, and are examined in a world-survey format in terms of emic socio-cultural level, subsistence economy, and religion. I suggest that responses to disability are cultural specific, and that these individualized responses are filtered through cultural perceptions of reality and transformed into various treatment strategies of care, euthanasia, and abandonment, in addition to common discriminatory customs, such as limitations on marriage eligibility.
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CHAPTER 1

INTRODUCTION

Throughout much of anthropological history, there have been two orientations: the comparative, and the ethnographic. In the former, the object has been to investigate specific cultural traits of one group in comparison with similar traits of a separate group in order to promote inter-cultural understanding. The focus of the latter, the ethnographic approach, has been the in-depth exploration of the traits and meanings of a specific society. The combination of these two orientations has lead to the assumption that cultural reality, or cosmological logic, is a byproduct of responses to a variety of factors, such as social structure, subsistence requirements, or in some instances, a manifestation of underlying human universals, including sexual differences between males and females, and parent-infant care requirements. In this paper I will explore the relationship between perceptions of physical and mental normality and abnormality within a comparative framework. I believe reality is an amalgamation of various objective truths which confront members of a culture on a daily basis, individual experiences, folk explanations of why the objective world exists as it does, and material realities that can not be avoided. In other words, reality becomes subjective as the objective is perceived
through the cultural lends or worldview of the culture, and becomes further adapted as individuals gain experiential knowledge of the way the world works. These altered experiences are then internalized by individuals into their own “web of significance” (Wallace 1956:266) that becomes their personal worldview. This experiential bias, once internalized, is strong enough to cause dissenting opinions of the same experience, such that although one incident may be experienced by many individuals at the same time, each will interpret the event in terms of his or her own individualized backdrop of prior experience, enculturation, and level of internalization.

In Metaphors We Live By, George Lakoff and Mark Johnson state that our very conceptions are themselves grounded within other conceptions, such that every experience occurs amidst “a vast background of culture presuppositions” (Lakoff and Johnson 1980:57). In effect, culture conditions our understanding and interpretation of experience, shaping our perceptions. This conditioning results in categorizations of perceptions, given known or accepted cultural presuppositions, leading to a remodeling of reality in favor of those culturally defined conceptual categories which interact with each other to enforce the acceptable worldview, in whatever culturally specific form it may take.

This explanation of reality becomes important in view of the purpose of this study, that is, the cross-cultural analysis of the perceptions of and treatment toward the members of a universal sub-culture, specifically, the physically disabled. Rather than comparatively examining a specific trait of two specific cultures, this study diachronically explores the interplay between objective and cultural reality in
terms of the effects of the former and the latter with regard to the status of the
disabled, as reflected in their interactions with their able-bodied counterparts on a
world level.

It is my thesis that the differentiation of able-bodied individuals from their
disabled counterparts is found in every culture and thus is universal in nature.
Physically or mentally abnormal persons are categorized either at birth or at the
onset of abnormality, however, the treatment a person receives will derive from
culture-specific interpretations of the particular handicap. In this way, recognition
of disabled individuals is less a cultural construct than a product of perception.

This study will not analyze the perceptions of the disabled toward their
dominant cultures, as such information is not available with the Human Relations
Area Files, the primary source for cross-cultural investigation. The primary purpose
is to identify the ways in which the disabled are stigmatized by different cultures
around the world. The leading theories of social interactionism, addressed in
Chapter 2, argue that stigmatization (Goffman 1963) and categorization (Douglas
1966) should be universal in nature, while post modernist interactionists argue that
disability is a cultural construct (Barton 1993, 1996) based upon subjective
interpretations within the cultural ideology. This study seeks to determine whether
or not disability is universally stigmatized, thereby nullifying the hypothesis of its
being entirely a byproduct of cultural construction, and to provide an explanation
for the universality of stigmatization as a conceptual category.

This study will examine how disability is perceived and stigmatized around
the world, by examining the Human Relations Area Files for actual treatment
toward disabled individuals, thereby creating a much needed database of able-bodied-disabled social interactions. The demonstration that every society selects certain groups for marginalization or rejection is significant, in that it is the first study to treat disability as a human universal. Although the need for a cross-cultural examination of the stigmatization and treatment of the disabled has long been noted (Groce 1984), no such exploration has been attempted. Indeed, no studies of treatment of the disabled in terms of specific cultural areas have been undertaken, and existing cross-cultural examinations consist of ethnographies of single cultures, or comparisons of a handful or related or unrelated cultures. This study is the first attempt to study disability in world-survey format.

For the purposes of this study, physical abnormality must be marked, that is, visible to the anthropologist conducting the ethnography included with the Human Relations Area Files database, and the following definitions of terms apply: Normal refers to any able-bodied individual possessing the above mentioned species normative capacities, i.e., walking, hearing, seeing, and who does not present any overt irregularity of appearance, such as a cleft-palate or other impairment obvious to the anthropologist. Abnormal, then, refers to any person not meeting the above criteria. This, of course, might lead to assumptions of bias on the part of the researcher, and certainly the usage of the terms “normal” versus “abnormal” may be offensive to some. In terms of this study, however, abnormality is not an assumption of a flawed character, and is used solely to convey a person who is outside the normal range of species variation, or who lacks certain capacities found in most members of the species.
CHAPTER 2

A REVIEW OF RELATED LITERATURE

Although disability has been widely studied by sociologists, social workers, and others, the anthropological contribution to the subject is very limited. Theoretical areas most commonly utilized historically, include the highly racist Social Darwinism of the Nineteenth century (Plato n.d.), interactionism (Goffman 1963; but see also Davis 1961), symbolic analysis (Douglas 1966; Parsons 1958; Needham 1979; Ryan 1976; see also, Bryant 1994; Linveh 1982; Mackleprang and Salsgiver 1996), cognitive studies, particularly cognitive linguistics (Blaska 1993; Lakoff and Johnson 1980; Whorf 1956; Zola 1987, 1993), and postmodernism (Barton 1993, 1996). The vast majority of anthropological literature consists, in addition to Douglas’ symbolic analysis, of autobiographical accounts (Murphy 1990), and historical or ethnographic studies (Frank 1981; Groce 1984; Gwaltney 1970; Gusinde 1937; Kojima 1977; Landor 1893; Merker 1910; Murphy 1990; Pilsudski 1910; Scheer 1984). Other studies include descriptions and case studies conducted by professionals within the field (Hayden 1981), as well as non- anthropological autobiographies by the disabled themselves (Carling 1962). Additionally, special mention must be made of the work of medical anthropologists.
(Helman 1994; Mascie-Taylor 1995; see also Orlanski and Heward 1981; Starkloff and Starkloff 1993), on body imagery and the role of the sick, which contribute to the liminality of the physically disabled.

Historically, the treatment of the disabled in Western societies has revolved around Social Darwinism and the concept of eugenics. Social Darwinism employs theories of heredity and, what Spencer termed, “the survival of the fittest” (Garbarino 1977:23). Social Darwinism was used to justify extreme opinions and acts of bigotry and eugenics.

One of the earliest examples of a eugenics-oriented approach akin to the Social Darwinism of the later Nineteenth century is found in Plato’s Republic. Plato states that in his idyllic society, “those who are not [wellborn], such as are defective in body, they will suffer to die” (Plato, The Republic, Book III, 410a), and again, with regard to infanticide, “the offspring of the inferior, and any of those of the other sort who are born defective, they will properly dispose of in secret, so that no one will know what has become of them” (Plato, The Republic, Book V, 460c. See also, Plato, Sophist, section 228, for a comparison of disease and deformity to the two types of evil, vice and ignorance.)

Interactionists focus upon the manifest and latent processes of social interaction in terms of cultural constructs. They do not generally compare behaviors cross-culturally, but rather seek explanations for the observed interactions of individuals within a given culture. With regard to the study of disability, social interactionist theories primarily revolve around Irving Goffman’s work on stigmatization. Goffman defines a stigma as a “special relationship between an
attribute and a stereotype” (Goffman 1963:4). Stigmatization is intensified by what Goffman terms the primal scenes of sociology, which arise at first meetings when one party presents with an unanticipated differentness, leading to feelings of uneasiness and awkwardness. “By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination... reducing his life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents...” (Goffman 1963:5).

In Goffman’s theoretical scenario, concepts of inferiority and danger are connected more with attributes, such as character flaws on the part of the stigmatized individual, hence, “We tend to impute a wide range of imperfections on the basis of the original one...” (Goffman 1963:5). Dexter, as quoted in Goffman, provides an example of this type of assumption, “[It also happens that] if a person of low intellectual ability gets into some sort of trouble, the difficulty is more or less automatically attributed to “mental defect” whereas if a person of “normal intelligence” gets into a similar difficulty, it is not regarded as symptomatic of anything in particular” (Goffman 1963:15).

With regard to feelings of uncertainty and awkwardness, Davis concurs, and states, “Whether the handicap is overtly and tactlessly responded to as such, or... no explicit reference is made to it, the underlying condition of heightened, narrowed awareness causes the interaction to be articulated too exclusively in terms of it. This... is usually accompanied by one or more of the familiar signs of discomfort and stickiness: the guarded references, the common everyday words
suddenly made taboo, the fixed stare elsewhere, the artificial levity, the compulsive loquaciousness, the awkward solemnity" (Davis 1961:123).

Stigma, itself, of course, may be positive, negative, or neutral in nature. Positive stigmatization occurs when particular associations are made which tend to somehow promote the positively stigmatized individual above other members of the group. An example of this is the common Western assumption that blind persons develop extraordinary powers of hearing, touch, or taste, to compensate for their lack of sight. The truth, of course, is that while some blind individuals may have more acute hearing than non-blind persons, is it not normative for the population of blind persons *in toto*. An additional example, one readdressed in later chapters, concerns the assumption of positive powers on the part of the stigmatized, such as the belief that one type of disability translates into shamanistic ability, or entails the gift of prophesy. Conversely, negative stigmatization represents quite the opposite, and a common example from Western culture might include the tendency of non-paraplegic or otherwise wheel-chair using individuals to assume that persons in wheelchairs are somehow lacking in other areas, such as intelligence, or the ability to hear, resulting in staggered or raised speech to ensure understanding on the part of the disabled individual. Further examples from the present study might include the assumption that the person is somehow evil, either possessed by a demon of some sort, or possessing the ability to call upon dangerous supernatural forces in order to harm another individual or an entire community. Neutral stigmatization, then, becomes that type of marginalization in which the person is assigned neither positive nor negative attributes, but simply exists in a state of
otherness, set apart from his or her cohorts. Traditional examples might include the teasing of a disabled individual, denoting the marginalization, but also reflecting an assumption of harmlessness on the person’s behalf.

Symbolic analysis shares much with the Interactionist perspective, both in attention to cultural categorizations and in explanations of the ways cultures assign meaning to various elements found in the society and how those meanings are interpreted and acted upon by members of the culture. In her work, Purity and Danger, Mary Douglas (1966), discusses cultural concepts of pollution and taboo connected with culturally constructed categorizations. While Douglas discusses disability to a very minor degree, it is apparent from an overview of the literature that many societies, in addition to many individuals within various societies, interpret disability as something dangerous, and construe disabled individuals as inferior, or polluted. There is an association of guilt presupposing character pollution, or a taboo violation on the part of either the disabled or someone connected with them, that sets the disabled apart from the truly human, and attaches overriding cultural theories of causation to every interaction.

Hence, social interactions of the disabled are directly correlated to causation theories, especially those involving dirtiness or pollution. Social inferiority is either overtly manifested in economic terms, or more esoterically stated in ideological systems. Causation of disability is seen in terms of either naturalistic, i.e., accidental, or personalistic, i.e., supernatural, forces, and the treatment of the disabled, the interactions between the disabled and able-bodied, and actions directed either toward or against them, necessarily revolve around and support cultural
constructs, including theories of causation. Frequently, this scenario involves overt statements of personal responsibility, again, either on the part of the disabled individual herself, or as traced to certain actions on the part of her parents or other relatives. It is a pragmatic example of blaming the victim which allows other members of the society, not thus afflicted, to convince themselves that they and their descendants will avoid a similar fate providing specific customs are adhered to in specific manners. Two examples of this follow:

1) The Ainu of Japan have a high incidence of both cleft-palate and strabismus (crossed-eyes). Accordingly, they have developed specific taboos against expectant mothers ingesting certain foods, such as lobster and fowl in order to prevent both conditions (Pilsudski 1910:763). In instances where the child is born without the deformity, the members of the culture are confident that the proscribed behaviors have been successfully avoided; in those instances where the deformity exists, then it is the parent, and not the ideology, which has failed.

2) The ideological system of the Masai contains both naturalistic and personalistic causation theories. In terms of personalistic causation, the ideology contains both animistic beliefs in a variety of extrahuman spirits, and animatistic beliefs concerning the vitality of inanimate objects. The Masai believe that both types of personalistic forces intervene to punish or reward individual behavior, and therefore, have taboos against mistreating the disabled. If, for example, an expectant father were to tease an invalid, the Masai believe the unborn child would be stricken with the identical malady (Merker 1910:5). This is, obviously, a behavioral proscription which again allows the assignment of guilt to misfortune,
thereby providing an emically reasonable explanation for the presence of birth
defects within Masai culture.

A further example, one with which we are undoubtedly more familiar,
stems from the Judeo-Christian tradition, where disability was commonly viewed as
a direct embodiment of divine punishment for the sins of the disabled or their
Using as examples Leviticus 22:22-23, which discusses the unsuitability of
deformed, blind, or otherwise abnormal animals for all but the most benign
sacrifices, Bryant argues that deformity was associated with inferiority early on
(Bryant 1996:92). This proscription continues in terms of denial of access to the
priesthood by disabled individuals (Leviticus 21:17-21), while additional verses can
be found relating to inferiority with regard to specific proscriptions against lepers
(Leviticus 13 and 14) and the interpretation of leprosy as being a divine
punishment or social death (Exodus 4:6-7; Numbers 12:20; 2 Kings 5; and 2
Corinthians 19-21). Hence, it is apparent from even a most brief reading of the
Judeo-Christian scriptures that the disabled were separated from society at large by
a sort of social death. Additional clues to this include the common Biblical
descriptions of the disabled or mentally ill as being dressed in rags, dirty, or
hungry, suggesting that they lacked the social networks available to members of
the culture at large.

Parsons also speaks of illness as a socially constructed concept. Although
Parsons was directly addressing mental illness in American culture, he makes the
point that cultures respond differently to issues of health and illness, due to
certain cultural categorizations, which in turn relate to broader cultural expectations (Parsons 1958). Needham (1979), concurs, stating that classificatory schemes are culture specific, that is, cultures categorize and classify in terms relevant to themselves. Ryan (1976), would undoubtedly agree that the reasons any given society employs to label or stigmatize individuals is based upon internal values of the citizenry.

Cognitive linguists examine the relationship between words and reality. Their interest lies in the ways in which people perceive of their world through the use of symbols (words) and metaphor. In this vein, Zola has stated that, “Language... has as much to do with the philosophical and political conditioning of a society as geography or climate... people do not realize the extent to which their attitudes have been conditioned to ennoble or condemn, augment or detract, glorify or demean... Prejudice is not merely imparted or superimposed. It is metabolized in the bloodstream of society” (Zola 1993:15, italics added).

The language we use involves conceptual metaphors of reality. Language becomes a means of classifying and categorizing culturally perceived reality (Lakoff and Johnson 1980:3-6). Benjamin Whorf (1956) would most certainly agree, due to his belief, in conjunction with Edward Sapier, that language shapes peoples perceptions of the world. He stated specifically that, “We cut nature up, organize it into concepts, and ascribe meanings as we do, largely because we are parties to an agreement to organize it in this way - an agreement that holds throughout the speech community and is codified in the patterns of our language (Whorf 1956:213).
In accord with Goffman's theory of stigmatization and assumption of attributes, Zola notes that in mystery novels disabled individuals are often introduced by their disabilities, and these introductions imply knowledge about their characters. For example, we read about "the dwarf", "the blind man", "the one-armed", "the one-legged"... The disability is emphasized... No other physical or social descriptor appears with such frequency" (Zola 1987:485). He adds that such practices "reinforce an association between disability, evil, and abnormality" (Zola 1993:17).

Continuing along these lines, Joan Blaska (1993) theorizes that disability language contributes to handicappism, that is, the discrimination of the disabled, by combining concepts of physical or mental ability with issues of empowerment. In addressing the stigma associated with the terminology revolving around disability, Blaska cites Hadley and Brodwin's (1988) contention that language has been used to portray disabled individuals in "stereotypical, imprecise or devaluing ways" (Blaska 1993:25), and suggests abandoning derogatory and negative terms in favor of more correct "person-first" replacements, such as 'normal development' rather than 'normal child', 'has a visual handicap' in place of 'is blind', 'uses a wheelchair' rather than 'is confined to a wheelchair' (Blaska 1993:28-29). These replacement terms remove the individual from a descriptive and therefore passive stance of being afflicted, victimized, or different, to an active, empowered role. Approaches to language interpretation and restructuring reflect the more widespread movement towards mainstreaming or normalization, and one wonders whether or not changing the label applied will ultimately effectively change perception.
Postmodernists believe that all cultural reality is constructed. Barrett has written that "Postmodernists argue that it is meaningless, and even immoral, to search for generalizations, laws, evidence, verification, all of which in their view dehumanize people by objectifying them" (Barrett 1997:32).

Postmodernist Len Barton has argued that disability is a culturally created category in and of itself (1993), and points to capitalism as a major cause of the problems of interaction encountered by so many disabled individuals (1993, 1996). He states that to label someone as disabled is to assume there is some sort of standard to which the individual in question is being compared, stating that "'able-bodiedness' is seen as the acceptable criterion of normality" (Barton 1993:237). He adds, after Hahn (1986), that disability arises "from the failure of a structured social environment to adjust to the needs and aspirations of citizens with disabilities rather than from the inability of a disabled individual to adapt to the demands of society" (Barton 1993:237-238). Hence, in Barton and Hahn's view, it is the society, and not the impaired individual, which is handicapped.

Autobiographical accounts of disability include the work of the late anthropologist, Robert F. Murphy, who suffered from a debilitating and incurable spinal tumor. Murphy wrote that his "identity lost its stable moorings, and has become contingent on a physical flaw" (Murphy 1990:105). He added that "the four most far-reaching changes in the consciousness of the disabled are: lowered self-esteem; the invasion and occupation of thought by physical defects; a strong undercurrent of anger; and the acquisition of a new, total, and undesirable identity" (Murphy 1990:108).
Murphy’s belief was that the disabled are treated disparately because they are threatening. Consequently, he stated, “We are subverters of an American Ideal, just as the poor are betrayers of the American Dream... The disabled are constant, visible reminders to the able-bodied that the society they live in is shot through with inequity and suffering... that they too are vulnerable” (Murphy 1990:116-117).

With regard to Goffman’s theory of stigmatization, Murphy acknowledged the uneasiness of interactions, noting that both the able-bodied and the disabled approach cultural scenes in line with cultural guidelines. When these cultural rules are violated, the people involved are uncertain as to what to expect from each other. This is further complicated by the transformed attitude of the disabled (Murphy 1990:87). The final result of this uneasiness of interaction is that the disabled exist in a more or less permanent state of liminality in terms of interaction with the larger external social environment, liminality being that state of existence found between socially defined roles. They are unrecognized members of the group, placed literally “betwixt and between” (Turner 1964) their able-bodied cohorts. Indeed, Jessica Scheer, a student of the late Dr. Murphy, has compared the similarities between the treatment of the disabled and the elderly with the social position of adolescents, noting that the three groups are marginalized members of society, each being assigned ‘non-adult’ status (Scheer 1984).

Diachronic ethnographic studies have not focused specifically upon the treatment of the disabled, but consist primarily of random inclusions and footnotes in larger ethnographic works. A brief overview of these might include the ethnographies of Landor (1893), and Pilsudski (1910) working with the Ainu;
Gusinde (1937) studying the Yahgan; and Merker (1910) in the field with the 
Masai.

An issue-oriented possible exception to this would be the work of Groce 
(1984), who calls for a cross-cultural analysis of the concepts of normality and 
abnormality, calling assumption of generalizations an ethnocentric error on the part 
of researchers. Oddly, she selects for study the case of the deaf of Martha’s 
Vineyard, Massachusetts, rather than specifically addressing the issue in cross-
cultural context, and justifying her selection by suggesting that in this instance, the 
deaf are considered ‘normal’ by their hearing counterparts (Groce 1984:202).

Gwaltney’s (1970) cross-cultural analysis of the interdependence of children 
and the elderly in a small Mexican community demonstrates that not all cultures 
perceive of all impairments as handicaps, and that some institute forms of behavior 
designed to bring together different factors of society in mutually beneficial ways. 
Both Gwaltney’s study and the afore-mentioned study by Groce demonstrate the 
applicability of Goffman’s stigmatization theory, which, to reiterate, includes 
positive, negative, and neutral forms, with the former illustrating positive 
assignment via specific cultural constructs aimed at inclusion, and the latter 
iluminating a neutral form, i.e., the acceptance of deafness as ‘normal’.

Kojima’s (1977) culture-specific examination of the disabled in Japanese 
society, defined disability in terms of extreme social stigma. She noted that as 
recently as the 1970s Japanese families continued to place their disabled members 
in institutions, lest the knowledge of that person by the society at large impact 
the life chances, i.e., potential marriage and employment opportunities, of non-
disabled family members.

Frank's (1981) doctoral dissertation consisted of the life history of a congenital amputee, in and of itself a fascinating story, and yet the story of a single life tells us little about the conditions of other, perhaps less-extremely disabled, individuals at the same time period. Certainly, Frank has demonstrated the value of life histories to anthropology, however, in this situation, further work needs to be undertaken so that comparisons may be made and conclusions drawn.

Descriptions of the conditions of the disabled are provided by professionals working among them, as in the case of Torrey Hayden. A special educator, Hayden works with autistic children, and provides numerous examples of common interactions between the able-bodied and the disabled. Frequently, these interactions are unpleasant, as for example, the case of the suturing of a young autistic child's tongue without anesthesia, as reported by Hayden, who, unable to quietly endure the child's shrieking, asked the doctor to give the child a local anesthetic. "'The doctor turned to me... He said, 'You know he doesn't really feel it. These people, they have no true feelings. Only what they imagine. No point in wasting good medicine on them'" (Hayden 1981:98).

Additionally, there is the case of Finn Carling (1962), a disabled individual who wrote an autobiography of his life in Norway, entitled, And Yet We Are Human. The book opens with an account of eight year old Finn in a restaurant enjoying a meal with his family. He writes that a woman continued to stare at him throughout the meal, and, being both uncomfortable with her scrutiny, and being a child, he smiled at her. The woman screamed to the maitre d', saying
that she could not finish her meal with “that child in the room” (Carling 1962:2). The able-bodied can only imagine the effects upon self-perception caused by a lifetime of interactions of this sort, overtly stated, as in the above scenario, or not. Carling, however, takes it a step further, by discussing the case of a young boy who had accidentally shot a girl while out hunting. For the next several years, this boy was called a murderer, and avoided by everyone in the town. One day, at the age of 17, he passed a woman in the woods, and upon her screaming for mercy and pleading with him to not harm her, he beat her to death with his fists (Carling 1962:45). The story serves to illustrate that the self-perception of a single member of society has ramifications to other members of the group, and that stigmatization affects personality development in random ways, causing submissiveness, eagerness to please or feelings of guilt and shame in some persons, while leading to psychotic breaks in others.

Medical anthropologist Cecil Helman describes body image as the various ways in which an individual consciously and subconsciously perceives and experiences his or her body (Helman 1994:12). Helman provides Fisher’s definition of body image as incorporating “his collective attitudes, feelings and fantasies about his body” (Helman 1994:13), adding that we relate ourselves to others, specifically in terms of dichotomous distinctions such as healthy/ill, young/old, and fit/disabled.  

Persons in every society develop two body images: the physical - psychological and the social. These body images affect each other by enabling or limiting social interaction and experience by the messages communicated to others.
For instance, social image transfers into messages about gender, status (including clothing and other adornment, body alterations, etc.), occupation, level of education, and level of conformity to cultural ideals (in terms of body shape), while physical image defines us in terms of fitness, age grouping, and so on. Both social and physical image affect psychological image, or perceived self-worth (Helman 1994:12-16; See also Blackling 1977:9-10). Physical disability can have profound affects upon body image, by limiting experience and interaction, and establishing an underdeveloped sense of self-worth via the unattainability of cultural ideals.

The second area of body image that will be addressed here relates to bodily boundaries, or what Helman terms "Symbolic skins" (Helman 1994:16). These boundaries, which are both psychological and physical in nature, are culturally defined and responsive to individual circumstances, such as disability, illness, or surgery. Hall (1969) has defined four types of boundaries, as follows: "1) Intimate distance (0-18 inches) - entered only by those with intimate physical relationships with the individual; 2) Personal distance (18 inches to 4 feet) - less intimate contact, personal space; 3) Social distance (4 feet to 12 feet) - impersonal business transactions, casual social interactions; and 4) Public distance (12 feet to 25 feet or more) - no social or personal interaction occurs" (Hall 1969:113-129; see also Helman 1994:16-18).

Often, among the disabled, personal space is non-existent due to the real or perceived need for assistance with normal bodily functions, movements, or close observation, however, abuse of the disabled by caregivers seeking to maintain
control generally revolves around issues of personal space, personal property, and individuality. Disabled individuals speak of being ignored, mistreated, or otherwise made to feel inferior by medical personnel and educators. Orlanski and Heward (1981) present multiple case studies based upon interviews conducted with disabled informants. A persistent theme throughout the case studies revolves around the negativity of social interactions, negative experiences where the disability becomes a matter of primary focus, or of insensitivity on the part of the medical profession, inexplicable assaults, attempts to prevent individuals from using a viable language as a means of communication, and dismissals of personal achievements in light of the disability. This all serves to suggest that through being ignored, mistreated, or otherwise abused, the disabled are discounted, even by care-givers. They slip between categorizations of what it is to be normal, functional members of society, and are accordingly treated as different, less intelligent, lacking in status and value, and lose their individuality.

Starkloff and Starkloff, (1993), provide further case studies relating to abuse by caregivers, whether related to the disabled individual or not. Many of these violations have to do with issues of personal space and individual rights, as described in the following excerpt in which Max Starkloff describes a nursing home’s abuse of power by eliminating all conceptions of individual space, “There was a guy at the home who had been a regional opera star in his day, and of course, he loved to hear opera and had stacks and stacks of records. They told him that he was disturbing the other patients and they took his radio and records away. Here’s a man who spent his whole life in music and all of a sudden they
take it all away from him. But that was the way they did things. They’d threaten people to maintain control” (Starkloff and Starkloff 1993:63).

Additional examples include the case of an elderly couple who were vocally having intercourse in a suburban California hospital during the middle of the night. The couple, both in their 80s, happened to be admitted at the same time, and had been married for some 60 years. The husband had suffered a mild stroke, and the wife was a paraplegic with debilitating diabetes. Their children and grandchildren, worried about the effects of the elderly couple’s frequent sexual activities on their health, had placed them in separate nursing homes. The hospital staff, upon learning the circumstances, transferred the couple into a single room at night. Hospital social workers attempted to intervene on behalf of the couple, who, aside from the aforementioned health problems were mentally alert and continually demanded to be placed together in a nursing home environment, yet, the social workers met unified opposition from the grown children who insisted they were acting in the best interests of their parents (Personal knowledge).

Becoming ill is a social process involving the patient and the members of the social and familial networks (Helman 1994:110; see also Mascie-Taylor 1978:92). Ill people are expected to behave in culturally defined manners, such as abstaining from social obligations, i.e., work or school, and personal obligations, e.g., cooking and cleaning, with the understanding that members of their social networks will provide care and fulfill the patient’s obligations in so far as possible (Helman 1994:110). This is a reciprocal relationship, as the patient is expected to not only express gratitude, but also to willingly take the opposite role of
providing for the former caregiver, should the need ever arise.¹

Mascie-Taylor elaborates by stating that it is the sick person who sets the process of illness in motion by admitting to being ill and seeking help (Mascie-Taylor 1978:92). Illness is a cultural construct, with cultural predeterminations of symptomology, when help should be sought, what type of help should be sought, and cultural expectations of behavior of sick individuals depending upon the severity of the illness. Illness is a reciprocal relationship involving specific roles of patient and caregiver.

Part of the reason that the disabled are unwilling to assume the role of the sick, is that for the most part, they do not consider themselves to be ill, merely differently abled. The disabled have been immersed in the role of the patient by external, societal, classificatory forces. Accordingly, many health professionals, and the general public have traditionally been ill-prepared to deal with the disabled who in essence buck the system by refusing to fall into mainstreamed categories.

British social workers Eric Miller and Geraldine Gwynne describe the mixed feelings of caregivers of the physically disabled, stating, “We found ourselves subjected to pronounced oscillation of feelings. One day we would be overwhelmed with sympathy and pity for the plight of the disabled, doubly persecuted by their physical handicaps and by the destructiveness of the environment in which they lived. Next day we would see the staff as victims of the insistent, selfish demands of cripples who ill-deserved the money and care that were being so generously lavished upon them” (Dartington, et al, 1981:13).

Miller and Gwynne state that their admission has resulted in mass criticism
(Dartington, et al, 1981:13-14), however, their response is typical of many individuals who work with the handicapped, including disabled individuals themselves. Part of the responsibility of social scientists is to recognize their own feelings toward the group under study. Surely we must commend Miller and Gwynne for their honesty and willingness to address an issue which is glossed over by many in the social sciences. They explain that their “ambivalence in not unique...’Membership’ and ‘damage’ are somehow irreconcilable. Anthropological evidence of the various social devices that are used would support the notion of a basic, primitive wish to extrude -- even destroy -- the damaged member. Running against this wish, and perhaps arousing guilt about feeling it, are the obligations of family and fellowship; and a variety of mechanisms have been devised to defend societies and their members against the anxiety produced by this ambivalence” (Dartington, et al, 1981:13).

Throughout the years, people have grown more accustomed to encountering the disabled in social settings, however the stigma of inferiority and liminality remains constant, despite attempts at normalization, education, political correctness, and increased contact. Disability theorists seek to explain the phenomena in various manners.

Postmodernist theories of disability neglect to take into account the existence of a normative ability for the human species. The problem here lies in refusing to accept the existence of a bonafide condition, preferring instead to blame it on the society at large or on the researcher whose study they question. Again, the greatest problem with postmodernist theories is that they frequently
assign blame, yet offer no viable solutions in and of themselves, thus ending up as ghost theories, that is, ineffectual and faddish.

The work of Robert Murphy, an anthropologist who became disabled, provides us with valuable insight not otherwise attainable. His story and scientific association of the data he uncovered through his disease should serve to guide the direction of anthropological investigations of disability for generations to come, particularly in terms of motivations for cultural change of the stigmatization of the disabled.

The life histories and case studies should remind us of the problems faced on a daily basis by the millions of disabled around the globe, while studies of body imagery and the role of the sick remind us of the great impact of socio-cultural explanatory factors and categorizations upon a sub-group which is externally defined as ill.

To reiterate, it is not enough to examine the case of the disabled in a single society. Efforts must be made to approach the issue cross-culturally and diachronically in order to obtain factual information on the status of the disabled in various societies. No generalizations regarding causation of differential treatment of the disabled can possibly be drawn without the existence of a vast database of actual case studies and sound ethnographic fieldwork. The following chapters represent the author's attempt to establish such a world-wide database.
ENDNOTES


CHAPTER 3

HYPOTHESES AND METHODOLOGY

Research Hypotheses

The first hypothesis is that disabled individuals are separated from their able-bodied counterparts in every society. While this paper agrees that disability is in part a cultural construct, it attempts to go beyond the subjective and incorporate objective norms for the species, based in biological abilities. Any variation in standard human behavior will result in stigmatization. By standard human behavior, I refer to locomotion, the ability to speak, hear, and see, possess a typical body type, with two arms, two legs, and so forth, with slight variations of appearance being normative. Significant variance, such as cleft-palate, albinism, paraplegia, blindness, deafness, hunchbackedness, hermaphrodism, polydactyly (extra digits), or anything else contrary to the majority of the species (and here such things as height, i.e., dwarfism or giantism, are included), would be considered abnormal.

Far from believing that comparative normality (Barton 1993, 1996) is meaningless or immoral, the author believes that humans categorize by nature, and that doing so is natural human behavior. Suppose, for example, that you enter a
restaurant and are led to a table with several chairs. One of the chairs is an infant’s highchair, while the others are normal chairs for adults. You know immediately that the highchair remains within the conceptual category of ‘chair’, but recognize that it differs from the other chairs at the table. The recognition of difference is not a value judgement, but simply an acknowledgment that highchairs differ from chairs designed for adults. The same holds true for disability: the disabled are people, and yet, they differ from the able-bodied in discreet ways.

The second hypothesis states that disability is a also cultural construct. That is, because of the objective categorization expressed in the first hypothesis, every culture constructs its own conceptual categorization of disability. It is imperative to note, however, that no culture completely accepts or rejects all types of disability. The very fact that a group selects all physically disabled members as having special status is, in effect a type of stigmatization, albeit positive in nature, which raises the individual above normal status into a special category. Additionally, some cultures might select certain forms for marginality, while other cultures reject the same forms, or assign them to extremely negative status, if not killing them outright. Which forms are maintained and marginalized, and which are rejected or killed is a cultural variable, grounded within the conceptual categorization factors of that particular group. To be fair, Barton’s studies revolve around Western cultures, and the cultures within this study are vastly different in political and ideological structure, however, if disability is entirely a cultural construct, we should be able to uncover cultures who do not marginalize or stigmatize disabled individuals. In all honesty, this is beyond the scope of this study, which relies, as
it does upon the information available within the primary source, the Human Relations Area Files. However, it is the belief of this researcher that given adequate ethnographic research, we would be unable to find any cultures who do not conceptually set the disabled apart from their able-bodied counterparts, at least in terms of traditional practices compared with acculturated practices.

It should be noted that hypotheses one and two initially seem to constitute a logical flaw, however, this situation is remedied in light of the existence recognized human universals, such as the differential treatment of the sexes. Sexual differences, on a purely physiological level, are universal, such that a child either does or does not possess certain anatomical features. Thus, physiology becomes the basis for differences between the sexes. From this biological distinction spring a myriad of cultural assumptions and interpretations, which are positive, negative, or neutral and often constitute the primary basis for structuring men and women’s beliefs and behaviors towards one another. Hence, sexual differentiation is a human universal, albeit often wearing a cultural face.

Third, it is hypothesized that the frequency of occurrence of a specific disability will not, in and of itself, effect marginalization or rejection. Cultural treatment of a particular form with more logically be based in other factors, such as ideological and economic patterns. For example, if cleft-palate is considered evil or unlucky within a given culture, and the cultural ideology compels the killing of all people who are conceptualized as evil or unlucky in order to prevent disaster or other mishap, then every child born with cleft-palate will be killed regardless of the total number of children so afflicted. Only when the ideological system
provides an alternative explanation, or rituals designed to protect the rest of the community from the dangers posed by the child will the child’s life be spared. These alternative explanations may pre-exist in the traditional form of the culture, or may be adopted via various means, such as stimulus diffusion or acculturation, leading to the modification of the culture’s response to the child in question.

Fourth, both Goffman’s theory of the assumption of attributes on the basis of recognizable difference, and Douglas’ work on pollution and taboo as being connected with all things outside a culture’s conceptualized criteria of acceptability and the association of guilt or responsibility, will apply cross-culturally. Goffman’s theory will be found in perceptions of the disabled in that positive or negative abilities will be assumed, while Douglas’ theory will revolve around food and behavioral taboos and other preventative measures used with regard to assignment of blame for physical or mental infirmities.

Finally, the fifth hypothesis states that conceptual categorizations are far more important in determining whether or not the disabled will be provided with long term care than material, and especially subsistence factors. Simply stated, not all foragers will kill disabled members of their group simply due to their need for mobility. Anthropologists have often assumed that material strategies are primary in the disposition of the infirm or aged, however, it is hypothesized that other factors, such as conceptualizations of good and evil will intervene in some cases, leading the group to care for, rather than to abandon or euthanize selected forms of physical disability.
Methodology

Data was drawn from the Human Relations Area Files, with a total available dataset of three-hundred-thirty-four cultures. After an initial visual examination, i.e., literally visually inspecting the microfiche for presence or absence of code 732, Handicap, an additional eighty-eight cultures were dropped due to complete lack of data. Of the two-hundred-forty six remaining cases, additional cultures were dropped from the study upon microfiche examination due to the following reasons: 1) the ethnographer simply made an acknowledgment of the types of disability found in the culture and made no other comment about perceptions or treatment; 2) perceptions of disability were not discussed, or were only discussed with regard to leprosy, which was not examined due to the clearly negative associated connotations (see discussion on leprosy below); 3) the data consisted of photographs with no accompanying discussion; 4) data consisted only of etic or empirical analysis of disability, rather than focusing on emic interpretations; 5) conflicting information was found, such that one source mentioned stigmatization and another source denied that the disabled were stigmatized; 6) the data was unclear; 7) the file card was unavailable or missing throughout the collection and examination period; or 8) the microfiche was miscoded and no information was available on disability. Microfiche examination resulted in the dropping of an additional one-hundred-sixty-six cultures, leaving a total available dataset of eighty cultures with information on emic perceptions of and treatment toward mental or physical disability. No supplementary data was included within the study.
HRAF codes examined in addition to code 732, Handicap, included 734, Invalidism; 847, Infanticide; 843, Pregnancy; and 826, Ethnoanatomy. Code 845, Difficult and Unusual Births was dropped from the survey in that it focused primarily on difficult deliveries and the birth and interpretations of twins, hence, more pertinent data was found under code 847. Code 753, Theories of Disease, was also dropped from the study as the majority of data concerned primarily personalistic causation as it pertained to generalized illness, often neglecting disability and naturalistic causation entirely. Information specifically related to causation of disability, when at all available, was present under the above listed included codes, 732, 734, 847, 843, and 826.

While this study did not begin as an examination of the disabled from birth, it soon became apparent that a wealth of information regarding disability existed under code 843, Pregnancy, including information on food and behavioral taboos, food and other curative substances, and rituals designed to prevent disability. Rituals involved both pregnancy-related rituals, ranging from ceremonial actions involving the expectant couple and/or their consanguineal and affinal families, to the expectant mother's wearing certain amulets or charms designed to thwart evil influences. Appeasement rituals include sacrifices made specifically after taboo violations have occurred, and consist of sacrifices or chants directed to placate personalistic forces believed to cause retributory disability in either the unborn child or the person violating the taboo.

With regard to pregnancy related examinations of the data, no food or behavioral taboos or curatives were included unless the literature specifically stated
that the taboo or curative caused damage of some sort to the neonate. Thus, for example, information on the pregnancy restrictions of many cultures with known food taboos were excluded from analysis on the basis of insufficient data as to reason for the taboo, i.e., while an ethnographer might state that a pregnant woman is not to eat turtle, the taboo itself may revolve around either a disability or a prolonged labor, leading to the exclusion of that particular taboo from analysis.

Special mention must also be made of the mentally deficient and those suffering from leprosy. This is not, *per se*, a study of mental illness or leprosy, however, information is included on mental illness. The mentally deficient constitute a special class or category of disability, such that the defect may or may not be outwardly visible, depending upon degree of infirmity. Mental illness is not associated with the high degree of negativity found with regard to leprosy, and may therefore be either positively or negatively stigmatized, indeed, its potential for stigmatization is no more or less than for the forms of physical disability included within the study. Leprosy, however, presented the opposite problem, in that people suffering from the contagious disease are frequently seen as evil, and are cast out by their cultures. Due to fear of contagion, and the overwhelming stigmatization and separation of lepers from their cultures, lepers are more likely to be negatively stigmatized than other forms of disfigurement or disability. As such they are excluded from the study in the belief that statistical analysis of negative stigmatization would be markedly skewed by their inclusion.

Data for the eighty (80) cultures included within the study were collected
in accordance with the primary code sheet (see Appendix 1), and analyzed using SPSS Graduate Pack version 9.0 for Windows. All statistics were examined using Pearson’s Correlation Coefficient, descriptive crosstabulations, and frequency analyses.

Cases were analyzed in terms of presence of positive and negative stigmatization practices, types of disability both positively and negatively stigmatized, explanatory factors, and differential treatment in the form of social ramifications to the disabled or their families, non-lethal aggressive practices, such as teasing, and avoidance of the disabled. Food and behavioral taboos, the forms against which taboos existed, and the person(s) required to avoid those foods or behaviors were noted and compared. Preventative or curative substances were analyzed in terms of presence in the culture, and with regard to who utilized the substance. The above factors were also analyzed in terms of political complexity, descent systems, subsistence economies, and belief structure, in hopes of finding correlations between the observations and reported practices.
CHAPTER 4

ANALYSIS OF DATA

Each society was analyzed for presence of egalitarianism (n=24), and stratification (n=56), although no correlation between political complexity and perceptions and treatment of the disabled was expected. However, while both patterns exhibited high levels of caring for various forms of disability, a correlation was noted between egalitarianism and practices of euthanatizing the disabled (see Table 1).

<table>
<thead>
<tr>
<th></th>
<th>POL Pearson Correlation</th>
<th>EUTH Pearson Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>POL</td>
<td>1.000</td>
<td>-.357**</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.</td>
<td>.001</td>
</tr>
<tr>
<td>N</td>
<td>80</td>
<td>80</td>
</tr>
<tr>
<td>EUTH</td>
<td>-.357**</td>
<td>1.000</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.001</td>
<td>.</td>
</tr>
<tr>
<td>N</td>
<td>80</td>
<td>80</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level

Of the twenty-four egalitarian societies included within the study, fifteen reported practicing infanticide or euthanasia of individuals with adult onset physical
or mental impairment, compared with only fourteen of fifty-six stratified groups utilizing the custom.

This unexpected correlation leads the researcher to suggest that political complexity might influence disposition of the disabled in terms of higher rates of lower end subsistence strategies, such as foraging in comparison to agriculture. Upper end strategies, such as horticulture and agriculture necessarily include storage capabilities, while societies engaging in lower end economies, such as foraging, are forced to relocate in accordance to the location of flora or fauna availability. Table 2 demonstrates that political complexity does correlate with subsistence economy, however, Table 3 illustrates that the correlation involves stratification and agriculture, and not egalitarianism and lower end economies.

Table 2: Political Complexity x Subsistence Correlation

<table>
<thead>
<tr>
<th></th>
<th>POL</th>
<th>ECONOMY</th>
</tr>
</thead>
<tbody>
<tr>
<td>POL</td>
<td>Pearson Correlation</td>
<td>1.000</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>80</td>
</tr>
<tr>
<td>ECONOMY</td>
<td>Pearson Correlation</td>
<td>.554**</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.000</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>80</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).

Table 3 clearly demonstrates that the egalitarian societies included within the study are equally as likely to engage in horticulturalism, or slash and burn technology, as foraging, so that the possible explanation offered above seems unlikely at least with regard to the available database. An alternative explanation might be that political complexity reflects cultural religious beliefs, with egalitarian
groups exhibiting a greater tendency toward animism or animatism as compared

to higher level religions, such as Buddhism, Christianity, Hinduism, or Islam.
Lower end shamanistic religions would involve a more overshadowing concept of
evil and magic in daily life, while higher level religions include religious
specialization, and incorporate intermediaries between the common members of the
culture, deities, and magic.

Table 4 notes the correlation between political complexity and level of
religious beliefs, while Table 5, below, illustrates the findings via the use of a
descriptive crosstabulation. Interestingly, while the majority of egalitarian groups have shamanistic or animistic belief systems, the belief level is shared by twenty-one of the fifty-six total stratified groups. Although Table 5 tentatively supports the author's hypothesis that disposition of the disabled is related more to conceptual categorization, and especially with regard to conceptualizations of the nature of good and evil, than to material factors such as subsistence economies, more data is needed before conclusions may be drawn.

Table 5: Political Complexity x Belief Level

<table>
<thead>
<tr>
<th>Count</th>
<th>POL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Egalitarian</td>
</tr>
<tr>
<td>BELIEF</td>
<td></td>
</tr>
<tr>
<td>no data</td>
<td>3</td>
</tr>
<tr>
<td>shamanistic/animistic</td>
<td>20</td>
</tr>
<tr>
<td>higher order</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
</tr>
</tbody>
</table>

Kinship patterns were analyzed in terms of effects upon overall disposition of the disabled. Initially, the author believed that increased level of tolerance toward disability might be found in those societies manifesting a relatively increased status of women. However, the opposite was found to be the case (see Table 6), as matrilineal groups were found to be more likely than societies with either patrilineal or bilateral descent to engage in either euthanasia.

Obviously, conclusions can not be drawn from a sample size of seven cultures, however, it would be interesting to investigate the overall practices of both matrilineal and matrifocal societies with regard to the ill, aged, or otherwise
infirm in comparison with their patrilineal and patrifocal counterparts. The

Table 6: Euthanasia x Descent System

<table>
<thead>
<tr>
<th>Count</th>
<th>DESCENT</th>
<th>Patrilineal</th>
<th>Matrilineal</th>
<th>Bilateral</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>EUTH</td>
<td>absent</td>
<td>32</td>
<td>1</td>
<td>18</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td>present</td>
<td>15</td>
<td>6</td>
<td>8</td>
<td>29</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>47</td>
<td>7</td>
<td>26</td>
<td>80</td>
</tr>
</tbody>
</table>

perceived correlation between matrilineality and killing may, as stated above, simply
be due to the extremely small sample size, however, it may also be due to the
relatively higher status of women, and the presence of female kinship support
networks, who actively elect to not allow loved ones to suffer long term illness
or infirmity. The issue of elective euthanasia will be readdressed during the next
section, subsistence economies and treatment of the disabled.

Table 7: Subsistence Economies

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>forager</td>
<td>12</td>
<td>15.0</td>
<td>15.0</td>
<td>15.0</td>
</tr>
<tr>
<td>pastoral</td>
<td>6</td>
<td>7.5</td>
<td>7.5</td>
<td>22.5</td>
</tr>
<tr>
<td>slash</td>
<td>18</td>
<td>22.5</td>
<td>22.5</td>
<td>45.0</td>
</tr>
<tr>
<td>agr</td>
<td>44</td>
<td>55.0</td>
<td>55.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 7 presents an analysis of subsistence economies in terms of frequency
and overall percentage of the cultures in the study. Notably, while a correlation
was found between subsistence economy and treatment conventions, the correlation
involved only euthanasia in horticultural, or slash or burn, societies (see Table 8).

A possible explanation for the correlation includes religious beliefs, such that any
culture with a shamanistic belief system might believe that the disabled individual
is somehow dangerous to the society. Lacking successful rituals to either negate
the dangerousness of the individual or to appease the particular deities involved,
such a society might elect to kill the individual in favor of group welfare.

Interestingly, horticulturalism does correlate with shamanistic belief systems (see
Table 9) tending to support the above statement of conceptualizations of danger.

The correlation in Table 9 becomes very clear when we examine the
religious level of each type of subsistence economy, in Table 10, which illustrates
the clear preponderance of shamanistic tendencies for horticulturalism and higher
level belief systems for agricultural groups.

Table 10: Subsistence Economy x Belief Level

<table>
<thead>
<tr>
<th>Count</th>
<th>ECONOMY</th>
<th></th>
<th></th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>BELIEF</td>
<td>no data</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>shamanistic/animistic</td>
<td>10</td>
<td>3</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>higher order</td>
<td>2</td>
<td>28</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>12</td>
<td>6</td>
<td>18</td>
<td>44</td>
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</tbody>
</table>

It should be noted that foraging also correlates with shamanistic beliefs
(Table 11), however, mitigating factors such as hunting magic might intervene to
reduce the harm caused by the disabled individual, leading to a lack of a
correlation between foraging and euthanasia.

Table 11: Foraging x Belief Level Correlation

<table>
<thead>
<tr>
<th>FORAGE</th>
<th>FORAGE Correlation</th>
<th>Belief Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson</td>
<td>1.000</td>
<td>-.279*</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.012</td>
<td>.012</td>
</tr>
<tr>
<td>N</td>
<td>80</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BELIEF</th>
<th>Pearson Correlation</th>
<th>Belief Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson</td>
<td>-.279*</td>
<td>1.000</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.012</td>
<td>.012</td>
</tr>
<tr>
<td>N</td>
<td>80</td>
<td>80</td>
</tr>
</tbody>
</table>

*Correlation is significant at the 0.05 level (2-tailed).

Overall patterns of subsistence economy pertaining to treatment conventions
are presented in Tables 12, 13, and 14. Due to the significance of the data with
regard to the thesis, the tables are presented together for ease of comparison, and will be followed by both a lengthy discussion and further data analysis.

Table 12: Subsistence Economy x Care

<table>
<thead>
<tr>
<th>ECONOMY</th>
<th>CARE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>forager</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>pastoral</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>slash</td>
<td>18</td>
<td>18</td>
</tr>
<tr>
<td>agr</td>
<td>42</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>77</td>
<td>77</td>
</tr>
</tbody>
</table>

Table 13: Subsistence Economy x Euthanasia

<table>
<thead>
<tr>
<th>ECONOMY</th>
<th>EUTH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>forager</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>pastoral</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>slash</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>agr</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>30</td>
</tr>
</tbody>
</table>

Table 14: Subsistence Economy x Abandonment

<table>
<thead>
<tr>
<th>ECONOMY</th>
<th>ABANDN</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>forager</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>pastoral</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>slash</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>agr</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>14</td>
</tr>
</tbody>
</table>
With regard to Table 12, it must be stated that care, as discussed in the ethnographic literature available to the researcher, includes forms of institutional care. However, the ethnographers did not often distinguish between the two forms, and we are left not knowing how many disabled individuals are cared for by their families, and which receive some type of institutionalized care. Frequently, the primary researcher stated that institutionalized care was available, but made no comment with regard to actual use of the treatment option by the members of the culture, especially with regard to societies which had been acculturated into larger systems. Table 14, then, includes those instances of abandonment leading to either death or unknown outcome, and does not include institutionalization. Ideally, institutionalization would have comprised a separate category residing between care and abandonment, as it has characteristics of both, however, the data was simply not available to the author. With the above provision in mind, we now turn to an analysis of the data presented in Tables 12-14.

With regard to Table 12, we can say that of the eighty cultures included in the study, seventy-seven provide some sort of care to the disabled. Hence, care in some form exists relatively equally in the various subsistence economies, and no correlations are noted. Table 13 illustrates that euthanasia is practiced in thirty cultures, and physical abandonment to the elements occurs in fourteen societies. Interestingly, although seven out of twelve foraging cultures kill at least some of their disabled members, no correlation exists between the two patterns, this, of course, being explained by the low differential between those cultures engaging and not engaging in the practice. A correlation, as noted in Table 8, above, was found.
between horticulturalism, or slash and burn technology, and killing conventions, as eleven of the eighteen horticultural groups utilize this disposition option. Table 14 illustrates abandonment practices, with only fourteen of the eighty cultures included in the survey employing the custom. It is especially intriguing to note that over twice as many cultures kill rather than abandon the disabled, with a total number of thirty cultures reporting either infanticide or euthanasia of individuals with adult onset physical or mental disability compared with the fourteen cultures who practice abandonment.

Of great significance to the study at hand is the very fact that all cultures report utilizing a combination of strategies when managing disability. This is, of course, to be expected in light of the hypothesis that the conceptual categorizations of any culture are fundamental in determining overall treatment strategies employed, and take precedence over material considerations, such as subsistence economies.

Tables 12-14, illustrate precisely the patterns one would expect if the statement were true, in that if material factors were indeed key to treatment of disability, then we would not expect to find the exhibited range of practices. For example, if material considerations, such as subsistence strategies were critical in determining the treatment of disabled individuals, we would necessarily expect that care would primarily be found in agricultural societies, and then observed in decreasing percentages in horticultural, pastoral, and foraging societies, respectively. We would then expect the exact opposite with regard to the custom of killing, with foragers reporting more instances than pastoralists, who would kill more often
than horticulturalists, and finally, agriculturalists, at the higher end of the subsistence scale, should have the lowest percentage of the convention of all four strategies. Abandonment might exist in any form, but we might reasonably expect that like killing, foragers would employ the custom more often than groups utilizing other economic strategies.

According to the data contained in Tables 12-14, however, this is not the case, and therefore, the thesis statement that conceptual categorizations take precedence over material considerations in the determination of treatment options employed, is supported. Care is equally distributed between all types of economies, killing is found most often in horticultural groups, and pastoralists have the highest rate of abandonment (see Table 14). With regard to pastoralism and abandonment, the high percentage of cases may clearly be due to the low number of total cases (6) contained within the sample, and more research must be done before conclusions may be drawn; however, it is important to note that precisely the same percentage of foragers and horticulturalists abandon their disabled, which tends to suggest that material factors are not the sole determining consideration when electing to abandon an individual. Possible explanations might include an aversion to killing, however, in light of the overwhelming numbers of groups who utilize killing in comparison with those selecting abandonment, this explanation seems highly suspect. An alternative explanation, might be that when groups kill their disabled members rather than abandoning them to the elements, they are killing them out of love. Hence, the very act of murder becomes an expression of love.
This is, of course, a stunning possibility, especially in light of the tumultuous arguments in Western cultures over the issue of euthanasia. Is murder, as a means of preventing or ending suffering, an ethical act? This is a question that goes far beyond the subject of treatment of the disabled, and haunts the lives of everyone faced with terminal illness, both for themselves, and for their family members. It is quite probable that the data contained in Tables 13 and 14 barely touches the surface of a more widespread practice which reflects the ethical decision making of world cultures with regard to actively ending the suffering of loved ones. This suggests that a larger comparison of practices of killing and abandoning the aged, terminally ill, and otherwise infirm would be well worthwhile, both in terms of the euthanasia debate, and as a means of gaining a better understanding of emic ethical conceptualizations of love.

With regard to the custom of euthanasia, special attention must be paid to the practice of infanticide. While the data contained in Table 13 represents a merging of euthanasia practices, Table 15 separates infanticide from those cases involving the euthanasia of adults.

### Table 15: Infanticide Forms and Frequencies

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>no data</td>
<td>54</td>
<td>67.5</td>
<td>67.5</td>
</tr>
<tr>
<td></td>
<td>infanticide</td>
<td>20</td>
<td>25.0</td>
<td>92.5</td>
</tr>
<tr>
<td></td>
<td>abandon at birth</td>
<td>3</td>
<td>3.8</td>
<td>96.3</td>
</tr>
<tr>
<td></td>
<td>allowed to die</td>
<td>3</td>
<td>3.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>80</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Infanticide, for the purposes of this study, is defined as the active killing of a physically disabled infant, whether it be by strangulation, suffocation, live burial or live cremation. Twenty cultures report engaging in active infanticide either alone or in combination with the killing of adults with disabilities. Abandonment consists of the child being physically taken outside and abandoned to the elements or carnivores, and is reported in a total of three cultures. An additional three cultures allow disabled infants to die at birth; in each case, the ethnographer states that the infants are not actively killed and are also not abandoned, leaving us with few possibilities other than death from neglect, such as failure to feed, which would result in a relatively slow passing.

Interestingly, infanticide, as separated from general practices of euthanasia, does not correlate with subsistence economy, and specifically with horticulturalism, however, infanticide is more likely to occur in cultures with a shamanistic belief system, as noted in Table 16.

Table 16: Infanticide x Belief Level Correlation

<table>
<thead>
<tr>
<th>BELIEF</th>
<th>INFANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>BELIEF Pearson Correlation</td>
<td>1.000</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>80</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INFANT</th>
<th>BELIEF Pearson Correlation</th>
<th>1.000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sig. (2-tailed)</td>
<td>.017</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>80</td>
<td>80</td>
</tr>
</tbody>
</table>

* Correlation is significant at the 0.05 level (2-tailed).

With regard to the custom of abandonment, both as a means of infanticide and as practiced against adults, Table 14, above, records fourteen cases. The
cultures engaging in the custom are as follows: 1) Aymara; 2) Burma; 3) Burmese; 4) China; 5) Inca; 6) India; 7) Lepcha; 8) Navaho; 9) Papago; 10) Pygmies; 11) Rwala; 12) Shona; 13) Twi; and 14) Ute. Each culture was analyzed for evidence of altruistic behavior on the part of the disabled individual, reminiscent of the behavior of elderly Inuit who will sacrifice themselves for the benefit of the family unit in times of difficulty. However, no evidence of altruism was uncovered in the data available to the author. Although altruism might exist in these societies, such behavior was not evidenced on the part of the physically or mentally handicapped. In each case, the abandoned person was either left to the elements as an infant (see Table 15), tied to a post and allowed to die of thirst, led away from camp, or left behind by the group. Abandonment did not correlate with any other variable, including belief level.

Positive and negative stigmatization were noted in term of dichotomies, and here some definitions will be provided. Holy, as used in the study, includes common Western interpretations of holiness, and encompasses those who are emically considered to have been set apart by a deity and are therefore somehow closer to it than other members of the population. In this instance, individual actions are relatively unimportant, such that miracles need not occur, and yet, the individual is believed to be close to God. Evil, on the other hand, involves those persons who are either outright evil because of cultural conceptualizations of the evil nature of the form of disability from which they suffer, or who are believed to be born of demonic fathers, or who are believed to be possessed by evil entities. Unlike holiness, action is very important. The person is considered to
pose some sort of danger to either members of their affinal or consanguineal families, to the extended kin network, whether it be assorted family members or the entire clan or lineage, or to the culture at large. The danger might include outright murder of a family member, especially a father or uncle, or actively using their evil nature to cause calamity.

Lucky needs no explanation, the individual is simply thought of as either being a good omen, or bringing good fortune to the kin network or culture. Unlucky, on the other hand, exists in a realm close to evil, and includes those individuals who unwittingly pose some sort of danger. While evil consists of contrary acts, unlucky individuals have no free agency and cause damage by their very existence. Unlucky also includes those persons thought of as misfortunes to their families. The category of Shaman, both positive and negative, includes good or evil power and prophecy. Increased status incorporates a variety of conditions, including the status of sacrificial victim. Decreased status involves both lowered and scarcely human status. Special attention signifies those instances where the ethnographer mentioned positive or negative stigmatization, but did not specify what the status of the person was in terms of the other categories, and Other entails combinations, such as holy and lucky, or evil and unlucky, in addition to such things as vampire or cannibal status.

Table 17, below, indicates the types of positive stigmatization existing in the cultures examined. Nine cultures perceive of the disabled as holy, seven believe they possess shamanistic or precognitive abilities, four cultures each conceive of the disabled as either having increased status, or being worthy of special attention,
and three cultures imagine that certain forms are either lucky, or possess a combination of positive factors.

Table 17: Positive Stigmatization

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid no data</td>
<td>51</td>
<td>63.8</td>
<td>63.8</td>
<td>63.8</td>
</tr>
<tr>
<td>holy</td>
<td>9</td>
<td>11.3</td>
<td>11.3</td>
<td>75.0</td>
</tr>
<tr>
<td>lucky</td>
<td>3</td>
<td>3.8</td>
<td>3.8</td>
<td>78.8</td>
</tr>
<tr>
<td>shaman/seer</td>
<td>7</td>
<td>8.8</td>
<td>8.8</td>
<td>87.5</td>
</tr>
<tr>
<td>increased status</td>
<td>4</td>
<td>5.0</td>
<td>5.0</td>
<td>92.5</td>
</tr>
<tr>
<td>special attention</td>
<td>3</td>
<td>3.8</td>
<td>3.8</td>
<td>96.3</td>
</tr>
<tr>
<td>other</td>
<td>3</td>
<td>3.8</td>
<td>3.8</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 18: Positively Stigmatized Forms x Number of Cultures Reporting

<table>
<thead>
<tr>
<th></th>
<th>Holy</th>
<th>Lucky</th>
<th>Shaman</th>
<th>Increased</th>
<th>Special</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disfigured</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Cripple</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Blind</td>
<td>2</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaf</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleft</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dwarf</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Giants</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra Dig</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Miss Dig</td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperpig</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Albinism</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hunchback</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hermaph</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Cephalics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Ill</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Un. Physical</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

Table 18 addresses the various forms of disability which are positively

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stigmatized. As is readily apparent, more cases are reported in Table 18, than in
Table 17, above, due to the fact that few cultures positively or negatively
stigmatize only one form of disability. Both dwarves and the mentally ill are most
often perceived as being holy, followed by those with generalized disfigurements,
those suffering from hyperpigmentation, and albinos. Those born with extra digits
are most often considered lucky, while the mentally ill and the blind are reported
as having shamanistic or precognitive abilities. Finally, the mentally ill seem to be
slightly more likely to be assigned to multiple positive categories. Interestingly,
neither giantism (whether due to Marfan’s Syndrome or acromegaly), or micro or
hydrocephaly, were positively stigmatized.

Table 19 presents the types of negative stigmatization reported in the
cultures examined. A quick comparison of Table 19 with Table 17 illustrates the
greater degree of negative stigmatization in comparison with positive stigmatization,
something which can not be accounted for by material considerations alone. Of the
sixty societies reporting negative assumption of attributes, eighteen perceive of the
disabled as being of lower status than the able-bodied, and sixteen believe them to
be evil. Twelve societies perceive of disability as being unlucky, eight consider
them to be a combination of negative factors, and three each construe disability as
denoting negative shamanistic or prophetic abilities, or as being worthy of special
attention by their able-bodied counterparts.

Table 20 lists the negatively stigmatized forms of disability, however, it
must be reiterated that at least some of the cultures which positively stigmatize
(n=29) some forms of disability also negatively stigmatize (n=60) other forms,
thereby providing support to the hypothesis that cultures do not stigmatize all forms of disability, but that they will select certain forms for marginalization or rejection based upon their conceptual categorizations.

Table 19: Negative Stigmatization

<table>
<thead>
<tr>
<th>Form</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid no data</td>
<td>20</td>
<td>25.0</td>
<td>25.0</td>
<td>25.0</td>
</tr>
<tr>
<td>evil</td>
<td>16</td>
<td>20.0</td>
<td>20.0</td>
<td>45.0</td>
</tr>
<tr>
<td>unlucky</td>
<td>12</td>
<td>15.0</td>
<td>15.0</td>
<td>60.0</td>
</tr>
<tr>
<td>shaman/seer</td>
<td>3</td>
<td>3.8</td>
<td>3.8</td>
<td>63.8</td>
</tr>
<tr>
<td>decreased status</td>
<td>18</td>
<td>22.5</td>
<td>22.5</td>
<td>86.3</td>
</tr>
<tr>
<td>special attention</td>
<td>3</td>
<td>3.8</td>
<td>3.8</td>
<td>90.0</td>
</tr>
<tr>
<td>other</td>
<td>8</td>
<td>10.0</td>
<td>10.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>80</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 20: Negatively Stigmatized Forms x Number of Cultures Reporting

<table>
<thead>
<tr>
<th>Form</th>
<th>Evil</th>
<th>Unlucky</th>
<th>Shaman</th>
<th>Decreased</th>
<th>Special</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disfigured</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Crippled</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Blind</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Deaf</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Cleft</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dwarf</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Giant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extra Dig</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miss Dig</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hyperpig</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albinism</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Hunchback</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Hermaph</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Cephalic</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Ill</td>
<td>9</td>
<td>2</td>
<td>2</td>
<td>11</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Unsp. Phys</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

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Mental illness is most often categorized as evil by the data in Table 20, closely followed by those suffering from unspecified physical disabilities, and those who are paralyzed or otherwise crippled. Cripples are considered unlucky in five cultures, while the same is true for those with unspecified physical disabilities in four cultures. The mentally ill are slightly more likely than those with physical handicaps to be viewed as shamans or seers, however, all but five types of physical impairment and mental disability are regarded as lowering the status of the afflicted person. Here again, we note the lack of stigmatization against both giants and cephalics, in addition to the absence of those suffering from hyperpigmentation from the list of negatively stigmatized forms. The combination of data from Tables 18 and 20 tends to concur with the hypothesis that theories of disability causation will support the conceptual system of a culture.

Thirty cultures included in the study report some degree of social ramifications against the disabled or members of their family group (see Table 21). These discriminatory acts range from decreased marriage eligibility, economic sanctions such as barring of access to particular occupations, loss of social status, i.e., in terms of denial of access to ceremonial activities, marriage eligibility based upon the sex of the disabled person, a combination of factors, or other ramifications, such as blackmail or culturally sanctioned loss of personal property.

As is illustrated in Table 21, below, ten cultures normatively bar disabled individuals from marrying, four employ a variety of discriminatory practices, three ban them from taking part in cultural activities, and one culture each limits economic opportunities or bans marriage based on the sex of the individual. In
each case, with the exception of economic and marriage based upon sex, these discriminatory practices extend to family members other than the handicapped individual, with nine cultures reporting sanctions against both the individual and other members of the kin network.

Table 21: Social Ramifications x Persons Affected

<table>
<thead>
<tr>
<th>Count</th>
<th>AFFECTED</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>no data</td>
<td>self</td>
<td>self and other kin</td>
<td>Total</td>
</tr>
<tr>
<td>SOCRAM</td>
<td>no data</td>
<td>50</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>marriage eligibility</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>economic</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>social status</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>marriage based on gender</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>combination</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>21</td>
<td>9</td>
<td>80</td>
</tr>
</tbody>
</table>

This is critical in light of the work of Mary Douglas on pollution and taboo and the association of the two with guilt and responsibility. By extending social ramifications beyond the disabled person himself, the culture is in effect punishing those believed somehow to be responsible for or polluted by the condition. The relationship between guilt and responsibility will become more apparent in light of the next three analyses.

Surprisingly, curative or preventative foods or substances are known in only fifteen of the eighty cultures included within the study. Table 22 presents a crosstabulation of the presence of such substances and the person, or patient, who
must ingest or otherwise utilize the materials. Per the information in Table 22, eight cultures have preventatives for use by the expectant mother, six cultures utilize curatives to be taken by the disabled individual himself, and one culture has preventative substances for use by both expectant parents. It is noteworthy that sixty-five cultures do not have ethnomedical treatments or preventatives for disability, a fact which may be due to recognition of their ineffectiveness in treating physical or mental handicap.

Table 22: Curative Substances x Patient

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>CURATIVE</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>no data</td>
<td>65</td>
<td>65</td>
</tr>
<tr>
<td>self</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>exp. mother</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>both parents</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65</strong></td>
<td><strong>80</strong></td>
</tr>
</tbody>
</table>

Table 23: Food Taboos x Person Restricted

<table>
<thead>
<tr>
<th>TABOO</th>
<th>no data</th>
<th>present</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>no data</td>
<td>55</td>
<td></td>
<td>55</td>
</tr>
<tr>
<td>self</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>exp. mother</td>
<td>20</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>exp. father</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>both parents</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>55</strong></td>
<td><strong>25</strong></td>
<td><strong>80</strong></td>
</tr>
</tbody>
</table>

Food taboos, as noted in Table 23, were absent or not noted in fifty-five
cultures and were recorded in twenty-five societies. Although many more cultures had food taboos than the above table suggests, the majority were dropped on the grounds that the reason for the taboo was not specified (see Chapter 3). Of those food restrictions included in Table 23, twenty cultures, or 75%, directed taboos against expectant mothers, while three societies restricted intake to both expectant parents, and one culture, the Yap, had cultural rules surrounding the expectant father only, while allowing the mother-to-be to satisfy all pregnancy related food cravings. Additionally, one culture believed that it was the person himself who inflicted his own disability by ingesting taboo foods. Due to the low number of cultures containing food taboos, no correlations were found between assignment of blame and other factors. It should be noted that in those cultures reporting food restrictions, the vast majority are imitative in origin, such that eating fowl causes strabismus or crossed-eyes in the infant. These are determined to be naturalistic with regard to theories of causation, rather than personalistic, since no malice on the part of a supernatural agent is involved in the resulting deformity.

With regard to behavioral prohibitions, Table 24, below, illustrates the types of behaviors believed to result in disability, and the person(s) responsible for committing the behavioral violation. The violations are defined as follows: Teasing a disabled individual is believed to cause an imitative illness in an unborn child, however, the violation can occur at any time during the future parent’s life, and is not necessarily restricted to the gestational period. For instance, if a woman had teased a cripple when she was a small child, she might give birth to a cripple herself at some point in her reproductive cycle. The same is true with regard to
violating the cultural moral code. In this instance any sort of anti-status behavior, or adultery, is believed to cause deformity in either the disabled individual herself, or in a future child. Generic taboo violations include causing harm, whether

Table 24: Behavioral Prohibitions x Violating Party

<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>teasing</td>
<td>1</td>
</tr>
<tr>
<td>moral violation</td>
<td>1</td>
</tr>
<tr>
<td>preg. taboo</td>
<td>14</td>
</tr>
<tr>
<td>taboo, other</td>
<td>3</td>
</tr>
<tr>
<td>other</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ACTOF self</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>e. mother</td>
<td>1</td>
</tr>
<tr>
<td>e. father</td>
<td>1</td>
</tr>
<tr>
<td>both par</td>
<td>2</td>
</tr>
<tr>
<td>self &amp; other</td>
<td>1</td>
</tr>
<tr>
<td>other</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BEHAVIOR</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>teasing</td>
<td>1</td>
</tr>
<tr>
<td>moral violation</td>
<td>2</td>
</tr>
<tr>
<td>preg. taboo</td>
<td>3</td>
</tr>
<tr>
<td>taboo, other</td>
<td>24</td>
</tr>
<tr>
<td>other</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>46</td>
</tr>
</tbody>
</table>

intentionally or not, to a clan totem. This violation may or may not occur during gestation. An example of a disability resulting from a generic taboo violation would be the birth of an albino resulting from parental intercourse during daylight hours.

Pregnancy taboos are those behaviors specifically contraindicated during the period when the woman is enceinte. These include pregnancy related eclipse taboos, generally believed to result in hyperpigmentation caused by the woman touching some part of her own body during an eclipse, with imitative marks on the body of the child. Taboo violation and other consists of either a generic or pregnancy taboo violation combined with either teasing a disabled person or breaking the cultural moral code. Other includes sins of either an ancestor or of
the disabled individual herself in the current incarnation or in a previous incarnation.

As is apparent in Table 24, the vast majority of the forty-six cultures reporting behavioral prohibitions focus on pregnancy taboos, with twenty-four assigning causation to violations occurring during the gestational period. Of these twenty-four societies, fourteen directly hold the expectant mother accountable for violations, nine assign blame to both parents, and one culture, the Yap, consider the actions of the expectant father of greater import to the health of the unborn child than the actions of the expectant mother. Actions of the expectant father generally revolve around hunting or other subsistence economies, such that the accidental breaking of a bird’s wing prior to killing is believed to result in a deformed limb in the unborn child. An additional fourteen cultures perceive of disability as being related to a combination of behavioral violations.

Finally, fifteen cultures reported ritualistic behavior designed to prevent disability, of these, nine were pregnancy related, three were appeasement rituals, and three were classified as other. Due to the small sample size, no correlations could be made.
DISCUSSION, CONCLUSION, AND RECOMMENDATIONS

Discussion

Disability is a human universal; a part of the human condition, and as such, must manifest itself in various forms in every culture. Thus, the question is not so much whether disability exists universally, but rather must focus upon the forms that it takes, and the variety of cultural responses to those forms. Responses to disability are based in conceptual categorizations which are composed of interpretations of disparate physiologies combined with cultural constructs. Hence, we see that dwarfism is holy in one culture, and unlucky in another, while it’s counterpart, giantism, is neither positively nor negatively stigmatized. Nonetheless, if we were to compare the handicaps related with certain forms of dwarfism with those caused by acromegaly-generated giantism, we would find that the overall problems of both conditions are similar, the slight stature of the one being in stark contrast with the largess and brittle bones of the other, and whereas the dwarf by his stature might be limited with regard to the ways he can contribute economically, the giant finds himself in the same position, due to his fragile osteological system. Yet giants are not stigmatized, despite their physical
limitations, while dwarves are singled out either positively or negatively by various societies included within this study. Our own society stigmatizes both groups, and indeed giants are present in Judeo-Christian texts, most notably in the story of David and Goliath, who was most likely an acromegliac.

While stigmatization appears to be random in nature, it is far from being so. Stigmatization patterns follow precise cultural guidelines. The patterns do not relate to political complexity, descent systems, or economic strategies, but are contained within the overall belief system of the stigmatizing culture. However, it should be noted that not all shamanistic societies marginalize the same forms of disability, for that matter, neither do all Christians. Religious belief evolves around cultural specifics, or the needs of the culture, and these needs are dependant upon a variety of factors that work to allow generalized religious systems to take on specific characteristics as required by the believer. An example of this might be the sub-culture of the Latter-Day Saints, or Mormons, which began as a revitalization movement and recruited membership from those whose needs were unmet by Protestant beliefs. The overall religion, i.e., Christianity, remained the same for the most part, but a messianic component was added, specifically that Jesus came to America following his ascension, prophesied to the natives, and left a gold-plated book, i.e., the Book of Mormon. Further alterations were made, and the faith turned polygynous, primarily due to the desire for greater numbers of children than marriage to a single wife would allow, in accordance with religious teachings. Conversely, polygyny might have begun as a licentious desire for multiple wives with a corresponding change in the religion, however, the point
remains the same, that regardless of which condition arose first, the religion was altered to fit the needs of the believers. The same is true for other groups, religions are altered in accordance with specific needs, while retaining their overall form, whether it be Christian or shamanistic in nature.

With the exception of horticulturalism, no correlations were uncovered between subsistence strategy and treatment of the disabled. Horticulturalists predominantly adhere to shamanistic belief systems, and so while expected rates of euthanasia were not encountered in foraging societies, lack of rituals designed to reduce the dangers posed by the disabled might account for the correlation with slash and burn technology. While foraging groups are also chiefly shamanistic in nature, the lack of a correlation between this economic strategy and euthanasia might be explained via the presence of hunting magic. It should be reiterated that shamanistic religion also correlates with infanticide, with the majority of cultures engaging in active killing of physically deformed infants adhering to shamanistic beliefs.

This returns us once again to the supposition that murder might be committed out of love, and related more to the existence of relatively empowered women with extensive support networks. Although more societies care for the disabled than either euthanize or abandon them, we have no way of knowing the types of care provided since care is a subjective determination which varies with the ethnographer and might refer to a situation which is little more than abandonment, or may refer to maximal home-based attention. Thus we must rely upon treatment options which were detailed in the database, and conclude that
care ratio is an unknown factor, while levels of killing and physical abandonment are known and accountable. Given this, we might propose that euthanasia, which occurs with greater frequency than abandonment, is a humanitarian act. The converse, of course, is that euthanasia occurs out of lack of concern, or the desire to be rid of the person.

The rates and means of infanticide tend to direct us away from altruistic murder or euthanasia, and suggest that people kill the disabled in order to not have to deal with the problems connected with their handicaps. Religion might state that a certain child is the offspring of a demon, and must be destroyed, so the child is burned or buried alive in the name of preventing evil actions. However, we have already noted that religion is malleable, and like the above example of Mormon polygyny, it may be the case that originally people decided they did not want to deal with the disabled, and then changed their belief system to incorporate that inhumane quality and provide an external justification for their actions.

Religion is a reflection of both the highest aspirations and the most sordid nature of mankind. It is a amalgamation of our dreams and hopes and also our nightmares. Shamanistic belief systems tend to make encounters with the supernatural central to daily life, with beliefs in both animism, and animatism, which incorporate interactions with spirits of various life-forms and substances, such as animals, trees, rocks, and water, each of whom may be deified, or offended. Retaliatory responses to presumed offenses are readily available to explain physical or mental disability, and to be used as justification for positive or
negative stigmatization, various forms of care, euthanasia, or abandonment.

It is therefore, unsurprising that shamanistic beliefs tend to correlate with euthanasia and various forms of infanticide.

Conclusion

The interactions of the disabled have long been examined by sociologists, professionals within the field of disability studies, the disabled themselves, and a handful of anthropologists. Studies have primarily involved Western society, or have been of a limited nature, with comparisons being made of two or three cultures. A common assumption has been that adverse responses to disability have revolved around subsistence economies or other material factors, in the belief that cultures, especially foragers and pastoralists, which are forced to migrate in pursuit of food animals or better fodder for herds, are more likely to leave behind those who are unable to either keep up with the group, or contribute. However, the data demonstrated in the paper tends to suggest that this assumption is erroneous.

By making economic strategies of primary importance to the treatment strategies employed with regard to the infirm or aged, we have overlooked the possibility of other cultural traits, such as religion, occupying a central role. If a person is believed to be holy, then that person will be kept alive no matter what subsistence pattern is utilized. Other considerations are secondary both to level of religiosity, and the conceptual categorization of good and evil.

Therefore, stigmatization of the disabled is based in religious belief systems which reflect the ethics of the culture. Shamanistic groups tend to eliminate the
physically and mentally disabled in greater numbers than do cultures with higher orders of religion, such as Christianity, Hinduism, Judaism, or Islam. Perceptions of and responses to the disabled are directly correlated with level of religious belief, and with the exception of the shamanistic and primarily sedentary horticulturalists, do not correspond to methods of subsistence economy. Hence, religion is the key deciding factor regarding cultural and individually enculturated perceptions of and responses to disability.

**Recommendations**

The possible correlation between descent systems and responses to disability should be further investigated. If correlations are indeed uncovered, then the subject might be examined in terms of levels of care found in the varying descent groups, and levels of empowerment and networking of women. This might both shed light on the issue of mercy-killing and assist us to focus in on a different aspect of emic understanding of the nature of love. Additionally, further study should be undertaken with regard to assignment of responsibility for disability, such as behavioral violations like adultery. Several groups believe that pregnancy progresses in response to multiple sexual encounters between a husband and wife, and therefore construe disability as a direct result of adultery on the part of the wife, the disfigurement being caused by a mixture of sperm.

Finally, anthropological studies of emic conceptions of the nature of good and evil might provide further insight into the relationship between shamanistic level religions and perceptions of disability, while both anthropological and
sociological examinations of religious beliefs in connection with disability in Western society might prove very interesting in view of the tendency of particular belief systems, such as fundamentalism, to exist in certain areas of the United States. Such studies might assist normalization or mainstreaming projects on a regional level, explaining why Americans with disabilities tend to be stigmatized to a greater degree in some areas than in others.
1. **Primary Questions:**

1. **Political Complexity**
   - a. Egalitarian
   - b. Stratified

2. **Kinship Pattern**
   - a. Patrilineal
   - b. Matrilineal
   - c. Bilateral

3. **Subsistence Pattern**
   - a. Forage
   - b. Pastoral
   - c. Horticulture
   - d. Agriculture

4. What forms of disability are addressed?  
   - a. Disfigurement
   - b. Cripple
   - c. Blind
   - d. Deaf, Mute
   - e. Cleft palate
   - f. Dwarfism
   - g. Giantism
   - h. Extra digits/limbs
   - i. Missing digits/limbs
   - j. Hyperpigmentation, marks
   - k. Albinism
   - l. Hunchbacks
   - m. Epileptics
   - n. Hermaphrodites
   - o. Cephalic - micro or hydro
   - p. Lepers
   - q. Mentally ill
   - r. Other
   - u. Unspecified

4b. Pregnancy/food/behavioral taboos against which forms:  
   - a. N/A
   - b. A
   - c. B
   - d. C
   - e. D
   - f. E
   - g. F
   - h. G
   - i. H
   - j. I

5. Are certain types holy or lucky?  
   - a. N/A
   - b. Holy
   - c. Lucky
   - d. Powerful shaman
   - e. Holy and lucky
   - f. Unspecified high status
   - g. Sacrificial victim
   - h. Special attention

5b. Which forms:  
   - B
   - C
   - D
   - E
   - F
   - G
   - H

6. Are certain types evil or unlucky?  
   - a. N/A
   - b. Evil
   - c. Unlucky
   - d. Evil, unlucky
   - e. Vampire or cannibal
   - f. Scarcely human
   - g. Abominable
   - h. Lowered status
   - I. Special attention

6b. Which forms:  
   - B
   - C
   - D
   - E
   - F
   - G
   - H
   - I

7. What happens to the disabled in this culture?  
   - a. N/A
   - b. Cared for (includes minimal care)
   - c. Killed
   - d. Abandoned
   - e. Differential treatment - forms: C
   - f. K
   - g. A

---

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f. Diff - gender: C___K___A____
g. Diff - age of onset: C___K___A____
h. Diff - Other: C____K_____A_____

8. Cultural approval of non-lethal aggression towards disabled?  
   a. N/A  
   b. Teasing  
   c. Physical abuse  
   d. Withholding food  
   e. Combination of above____  
   f. Other

9. What social ramifications affect disabled or their kin?  
   a. N/A  
   b. Marriage eligibility  
   c. Economic  
   d. Social status  
   e. Marriage eligibility - gender  
   f. Combination of above____  
   g. Other

9b. Who is affected?  
   a. N/A  
   b. Self  
   c. Mother  
   d. Father  
   e. Both parents  
   f. Siblings  
   g. Self and Other Kin  
   h. Other family

10. Are the disabled avoided by others in this culture? - If yes, then why?  
    a. N/A  
    b. Fear of contagion  
    c. Moral Issue: blame the victim  
    d. Moral: divine retribution  
    e. Combination____  
    f. Other/Unspecified

11. Do certain foods cause disability?  
    a. N/A  
    b. Yes  
    c. No  

11b. Who must avoid these foods?  
    a. N/A  
    b. Self  
    c. Mother  
    d. Father  
    e. Both parents  
    f. Siblings  
    g. Self and Other Kin  
    h. Other family

12. Do certain foods or substances prevent or cure disability?  
    a. N/A  
    b. Yes  
    c. No  

12b. Who must use these foods?  
    a. N/A  
    b. Self  
    c. Mother  
    d. Father  
    e. Both parents  
    f. Siblings  
    g. Self and Other Kin  
    h. Other family

13. Do certain behaviors cause disability?  
    a. N/A  
    b. Teasing disabled  
    c. Violating moral code (adultery, actions perceived as anti-status/role, etc.)  
    d. Excessive pride  
    e. Laziness  
    f. Taboo Violation (injuring clan totem, etc)  
    g. Pregnancy taboo  
    h. Taboo violation and other violation  
    i. Other

13b. Behavior restrictions pertain to:  
    a. N/A  
    b. Self  
    c. Mother  
    d. Father  
    e. Both parents  
    f. Siblings  
    g. Self and Other Kin  
    h. Other family

14. Are there rituals to avoid disability?  
    a. N/A  
    b. Pregnancy Rituals  
    c. Appeasement Rituals  
    d. Preg & Appease  
    e. Other Rituals

15. In this culture, disability is caused by:  
    a. N/A  
    b. Accident of birth  
    c. Actions of human agent  
    d. Actions of divine agent  
    e. Combination of above_____  
    f. Unspecified

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16. This culture’s theory of disability causation is:  
   a. N/A   b. Naturalistic  
   c. Personalistic  
   d. Both naturalistic and personalistic
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VITA

Graduate College
University of Nevada, Las Vegas

Tommi L. White

Local Address:
202A Bruce Way
Henderson, NV. 89015

Degrees:
Bachelor of Arts, Anthropology, 1998
Boise State University


Thesis Examination Committee:
Chairperson, Dr. W. Jankowiak, Ph.D.
Committee Member, Dr. J. Swetnam, Ph.D.
Committee Member, Dr. M. Miranda, Ph.D.
Graduate Faculty Representative, Dr. D. Dickens, Ph.D.