Cross-Cultural Perspectives I
How To Study Healing Cross-Culturally?

Read: Farmer 1-79

I. How do we *do* cross-cultural analysis?

A. Anthropology tries to make the strange familiar, make the familiar strange

1. Observe another culture, analyze it, and present the analysis to others

a. Doing this might seem easy when the analysis depends on observations

1) Looking at agricultural practices, for instance

b. But what about things one doesn't observe?

1) Like what the agricultural practices mean to the members of the culture?

a) A possibility of not being able to make sense of one's observations until one understands what they mean to the members of the culture

b) You're no longer observing

2) Or things one doesn't observe nor believe: gods, ghosts, mythological heroes?

3) We classify these non-observable parts as "Culture X's belief system"

4) The Miner reading on the Nacirema illustrated, and implicitly criticized, some of the techniques anthropologists have used to describe beliefs they don't subscribe to

c. The phrase "belief system" immediately signals we are calling the truth status of these data into question

1) Statements using the word *belief* always entail the possibility of doubt in some respect

2) But doesn't this notion of *belief* distort the nature of the phenomenon being described?

a) Because, from the perspective of the members of the culture, these aren't beliefs, they're knowledge

b) In the same way that we don't say we "believe" in viruses, we **know** they exist

B. So, how do we make the strange familiar when we don't accept what people say as true?

1. One thing we shouldn't do is use condescending, patronizing language

a. Which you read in Miner's descriptions of Nacirema body ritual

b. Miner's piece is funny because so often this is exactly the language we use

2. Another thing we should avoid is making value judgments

a. The aim is, rather, to treating the material with respect, even though we don't believe it

3. And also try to step into an "as if" space; suspend our disbelief, try to understand it from the inside

a. All cultures are ethnocentric, but anthropological research tries to look at what we're seeing without making moral evaluations, at least during the analysis

b. This does *not* mean adopting a 100% cultural relativism

1) A kind of "different strokes for different folks"

2) We all must be morally responsible citizens, human beings

c. It means, rather, having a respect for difference

1) And, most importantly, trying to understand this difference from the insider's point of view

3. Acquiring a respect for difference is especially difficult in areas related to medicine

a. Because medicine is the most authoritative discourse of all the applied sciences

C. Examples illustrating the value of trying to understand a belief system from the inside

1. Someone says they hear voices

a. In the West this is a powerful indicator of serious disease—a psychosis—schizophrenia

1) There are all kinds of neuroses, but hearing voices is never a symptom

b. But someone in another culture who hears voices might be perfectly healthy

2. Or someone who goes into a trance

a. In the West the characterization is clinical, and negative: a pathology we call "dissociation"

b. But there are many examples in the cross-cultural record of very healthy people trancing, sometimes for the benefit of someone else or the entire community

c. When, for example, trancing allows contact with the spirit world and is seen by members of the culture to be a kind of preventive medicine

3. An exception in the West is hypnotism, which involves trancing, yet which is not seen as pathological

a. What do you think makes the difference?

b. Let's enlist our exercise on Wed. when we discussed how to characterize, define "disease"

1) There were prototypical diseases

a) Infectious

2) And others that qualify as disease but are not so prototypical because they don't involve an infectious agent—a parasite—invading the body

a) Genetic

b) Poisoning—is an external agent, but not alive

c) Diabetes, cardiac problems, etc.

3) Third are conditions that are not (yet) full-fledged diseases

a) Multiple chemical sensitivity; is doubted by some

c. The most prototypical examples of diseases were

1) Unwanted

2) Pathological physical/medical condition—something seen to be wrong

a) Pregnancy, even unwanted pregnancy, therefore wasn't a disease

3) Caused by an outside agent, protypically a living parasite

4) Diseases are seen to be dynamic processes with beginnings and (hopefully) endings—not a stable pathological condition like an impairment

d. Back to hypnosis

1) One chooses to go into a hypnotic trance, so it's wanted, and it will end at a chosen moment

2) One chooses it for a reason

a) Sometimes for a medical benefit: to reduce dental, childbirth pain

3) No outside agent

4) Still, hypnotic trance is poorly understood by many, so there are jokes about being hypnotized against one's will, etc.

D. If we are to succeed at "making the strange familiar" we need a descriptive, analytic language

1. Anthropology uses regular English for the most part

a. And some jargon, unfortunately

b. Some technical words, too

1) But nothing like the technical languages you have to learn to do physics, biology

2) Use of everyday language creates a problem, because we will use words that are loaded with meaning—several meanings, connotations, built-in value judgments

2. Anthropology uses words from the language of the culture being studied when necessary

a. You had to learn: *qaug dab peg* "the spirit catches you and you fall down"

3. We can translate terms in another language to "smallpox," or "malaria"

a. Farmer says this is problematic, giving *move san* as an example. Why?

b. A lot is lost in the translation

1) With respect to the complex, rich meanings terms have for the insiders

2) And our ability to understand the history of a given disorder occurring among a given local community

a) Which is why Farmer devotes a chapter of his book to Haiti's history

4. Hahn provides another example of efforts to "make the strange familiar" in his discussion of "culture-bound syndromes," which you'll read later in the course

a. Do we study these conditions, like *move san* without bringing in biomedical diagnoses?

b. Or should we hypothesize that the condition *latah* in Indonesia is in fact the "startle reflex" with another name?

1) What would *move san* be?

2) One student wrote: "The anthropologist seemed to be writing the disorder off as a psychosomatic problem as it is caused by problematic emotions. However, the physician describes the symptoms as a foliate deficiency and sees the problems as real medical problems. I am confused as to whether there are real medical problems that can be viewed as having different causes or whether the physical problems are really psychosomatic."

3) These are questions I imagine you all asked—many of you said you were confused—and why I assigned the article

c. What language should we use?

5. Hahn argues that if we are to avoid accusations of exoticization and orientalism

a. Miner illustrates exoticization by giving the impression that the Nacirema culture is bizarre

b. If we are to avoid accusations that we're exoticizing a culture, then, logically, we need to discover culture-bound syndromes in our own society

c. This is what many of you are doing for the first assignment

1) PMS is one possible candidate, so is anorexia

6. We will see another example of the difficulties we can encounter when trying to "make the strange familiar" in the article by Obeyesekere you'll read later on

a. He discusses how "depressive" thoughts constitute good Buddhist practice in Sri Lanka

a. In the West we would very likely agree that a "process of generalization of hopelessness...forms the central core of depressive disorder"

b. One practice Obeyesekere discusses involves intensively thinking about a decomposing corpse

1) Or actually sitting and observing one decompose, day after day

2) This sounds pathological—seriously morbid—to us

c. But Obeyesekere argues that for Buddhism, accepting that all is hopeless is seen as necessary to achieve enlightenment

d. These individuals aren't sick, they're good Buddhists, engaged in good Buddhist practice

e. Hahn, discussing Obeyesekere, mischievously suggests that perhaps a Sri Lankan would become depressed "when failing to overcome a contentment in daily life"

7. Clearly, what a behavior means to the people engaging in it is crucial

a. But we're all one species, and biomedicine sees bodies as biological objects

b. Merced hospital had no problem diagnosing Lia as having a severe form of epilepsy

8. So, should we reduce all instances of disease to biomedical categories and discard the rest as something else—mistaken beliefs?

9. Or should we be completely relativistic and say there's no point in making comparisons?

E. One way we're addressing this issue in this course is to "make the familiar strange"

1. Analyze biomedicine as if it were an exotic belief system

2. Ask about what "disease" means to people who believe in biomedicine, just the way we would with the Hmong

a. What we did on Wed.

b. Try to understand the characteristics of a prototypical disease for that society

c. And explore the margins of "disease"—syndromes, disorders, ailments—why are these so marginal in the belief system?

d. In the West we seem to see disease as

1) A somatic, physical manifestation

2) That impairs the person

3) And is unwanted

3. Inquire as to whether the society had "culture-bound syndromes"—conditions we see as disease that seem to occur only in our society

a. If so, these conditions will be very instructive, will teach us a lot about this society's belief system

F. Back to the issue of "the real"

1. A student two years wrote in her response that she has asthma and "I remember the shock and frustration I felt when a boy in my P.E. class told me asthma was purely psychological and therefore not a real disease"

a. People can die of asthma attacks: can something "not real" kill?

1) Yes; the example of "Voodoo death"

2. But is asthma "not real" in a similar way?

a. Hardly

b. First, let's acknowledge the put-down nature of the comment

1) A process of stigmatizing is going on

a) Nicely encapsulated in the word "real"—its opposite is "unreal"

1) Illustrates the point we discussed earlier in the course that moral evaluations of diseases and the people who contract them are found in all belief systems about health and disease

3. Asthma, in contrast to some other conditions, is a "real" disease in biomedicine

   a. Well documented, thoroughly accepted in our nosology, epidemiological studies, etc.

   b. Everything we do in biomedicine to culturally construct "real" diseases we have already done with asthma except to fully understand the underlying causes

   c. And we don't know why rates are soaring world wide (Center for Disease Control in 2002 registered over 17 million suffer); now kills nearly 5,000 Americans each year

   d. So, is mysterious in some ways…allergies? Ozone-filled smog? Athletic children higher rates. Around cigarette smoke higher rates

4. What's going on?

   a. The problem is with the concept "real," not the condition of asthma

   b. The implication of "not real" is that what this person has is "all in your head," imaginary

5. Let's return to our analysis of "disease" in the West and discuss why this student was told her disease wasn't "real"

   a. A very good illustration of the importance of holding off, temporarily, your outsider's need to decide whether something is "real" or not, and analyze it from the inside, from the insider point of view