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Medicine, rationality, and experience

An anthropological perspective

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located in linguistic practices and most typically embedded in narratives about life and suffering.[24]

Thus, despite powerful authorization by biomedicine and the biological sciences, the empiricist program in medical anthropology is deeply problematic. I will be arguing in the following pages that how we situate ourselves in relation to the underlying theoretical issues at stake here is extremely important for how we conceive a program for medical anthropology. How we situate our research in relation to biomedical categories and claims, the nature of authority we grant to biological and medical knowledge, the problems we see as central to the field, and the way we define the project in which we are engaged are all strongly influenced by our stance on these issues. More than this, I am convinced that medical anthropology is one of the primary sites within anthropology where alternative responses to the confrontation between historicism and the natural sciences are being worked out.

Although I have focused largely on epistemological issues in this first chapter, I want to foreshadow the argument to come by noting that all medicine joins rational and deeply irrational elements, combining an attention to the material body with a concern for the moral dimensions of sickness and suffering. In his Marett Lecture in 1950, Evans-Pritchard argued that "social anthropology is a kind of historiography" that "studies societies as moral systems . . . " In all societies, even in the modern world with overarching moral orders no longer intact, serious illness leads men and women to confront moral dimensions of life. It is after all a central task of "the work of culture" to transform human misery into suffering, and to counter sickness with healing.[25] Biomedicine, as other forms of healing, is of special interest because it combines the empirical or natural sciences with this primal task. It is thus both the privilege and the obligation of medical anthropology to bring renewed attention to human experience, to suffering, to meaning and interpretation, to the role of narratives and historicity, as well as to the role of social formations and institutions, as we explore a central aspect of what it means to be human across cultures.

2

Illness representations in medical anthropology: a reading of the field

In their extended essay on the perceived breakdown of coherent conceptual paradigms in anthropology today, Marcus and Fischer argue that our post-colonial self-awareness and a broad loss of faith in totalizing theoretical visions has provoked a "crisis in representation," which has in turn served as "the intellectual stimulus for the contemporary vitality of experimental writing in anthropology" (1986: 8). Little wonder there should be such a crisis. Despite our attachment to those with whom we have carried out research and our dedication to represent their interests and point of view in our writings, we find ourselves part of a discipline whose history is strewn with cultural representations which now seem profoundly ethnocentric, often clearly aligned with colonial regimes and those in power, explicitly gendered, and at times racist. Our embarrassment with this history is compounded by the fact that many of our informants and articulate intellectuals in the societies we study now read not only our own books and articles, but those of our predecessors as well. Their criticism of anthropology's legacy and of our own work gives the lie to our claims to speak for others, to represent them as they would represent themselves. Anthropological discussions of the past decade have thus become increasingly concerned with the nature of ethnographic representation, with our objectification and portrayal of "the Other," with the place of the author and those represented in the ethnographic text, and with the "authorization" of our portrayals and our claims to ethnographic knowledge.

Medical anthropology has had its own form of critical self-analysis in the past decade, arising not only from these general developments in anthropology and the human sciences but from characteristics specific to cross-cultural studies of illness, healing, medicine, and health care institutions. Medical anthropologists can hardly fail to acknowledge links between colonialism and early anthropological writing on medical "beliefs and practices," which resulted in the use of highly pejorative analytic terms for what Rivers called "medicine, magic and religion." But criticism of that early work has often been part of medical anthropology's specific form of "cultural critique." From its inception, anthropological

writing on "traditional medicine" has been linked to criticisms of biomedical theories as well as physicians, public health specialists, and medicine as practiced in our own society. The first explicitly "medical" anthropology, the applied work of anthropologists involved in international public health in the 1950s, was formulated not only to enhance the efforts of public health practitioners but as a critique of their cultural naiveté.[1] Members of societies toward which such efforts were directed are not "empty vessels," waiting to be filled with whatever health knowledge is being advocated by health educators, Polgar wrote in a classic essay outlining the fallacies typical of public health programs (Polgar 1963; cf. B. Paul 1959). Their "habits and beliefs" constitute elements in an elaborate "cultural system" (Paul 1955: 15), which the public health specialist would do well to understand before advocating new habits and ideas. As Benjamin Paul wrote, "If you wish to help a community improve its health, you must learn to think like the people of that community" (1955: 1). Early studies of folk illnesses and popular concepts of disease among members of American subcultures had a similar aim of criticizing physicians for their failure to understand the cultural forms through which such persons understood and responded to their illness (for example Rubel 1960, 1964; Clark 1959; Snow 1974).

These early studies led to more fully developed research on the great and little traditions of medicine and healing in India and China, elsewhere in Asia, and in Latin America, Africa, and the Middle East. The Wenner-Gren conference on "Asian Medical Systems," which resulted in the book edited by Charles Leslie (1976a), and the Fogarty International Center conference on "Medicine in Chinese Cultures," resulting in a book by that title edited by Kleinman et al. (1976), were key moments in the emergence of the comparative study of health care systems. While maintaining an element of critique of the cultural naiveté of physicians and public health specialists, the scholarship in this tradition has developed a distinctly anthropological analysis of health care systems, showing biomedicine to be one system among many and extending the challenge to biomedicine's hegemonic claims more generally.

Even more than criticizing medical practitioners for their failure to understand the richness of the medical ideas of their patients or the health care systems of those with whom they worked, studies of healing systems in traditional societies have often been designed explicitly or implicitly to demonstrate the inadequacies of "Western" medical ideologies and health care institutions. In the conclusion to one of the first full ethnographies of an ethnomedical system, Fabrega and Silver (1973: 218–223) outlined thirty-three propositions "that appear to underlie and guide the curing process" of the "Western Biomedical System" and the "Zinacanteco System" (in the Chiapas region of Mexico), set forth as diametrically opposed systems. Western medicine understands the body as a complex biological machine, while the Zinacanteco see the body as a holistic integrated aspect of the person and social relations. Our treatments are mechanical and impersonal, our healers characterized by distance, coolness, formal relations, and the use of abstract concepts; their curing makes use of emotionally charged

symbols, and the treatment relationship is characterized by closeness, shared meaning, warmth, informality, and everyday language. Western curing is aimed exclusively at the mechanical body, while Zinacanteco procedures are directed at social relations and supernatural agents. In this study and many which have followed, healing in other societies is found to have qualities increasingly absent from our own medicine. In many instances, a romanticized vision of the other is juxtaposed to a caricatured image of ourselves. Cross-cultural studies of healing have thus served to advance and extend a cultural critique of biomedicine and of North American and European societies more generally. In particular, they reproduce themes about the alienation of medicine from intimate social relations, the increasing bureaucratization and professionalization of the experience of illness, and the fragmentation of our soteriological vision, themes having wide currency both in medicine and broader social criticism.

A more political critique of medicine and international health emerged in the 1960s. Activists and scholars within anthropology, as well as members of American ethnic communities and Third World physicians and scholars, criticized the implicit acceptance by applied anthropologists and medical social scientists of the medical profession's Enlightenment claims that lack of knowledge and maladaptive behavior are the sources of ill health. Anthropology's concentration on folk beliefs and folk illnesses often excluded analytic attention to the distribution of health care, to social inequities and industrial policies which burden minority communities and the poor with ill health, to international policies that produce underdevelopment in the health arena, to barriers to health services that originate in medical practice rather than among the folk. The field thus ultimately failed to give adequate attention to macro-social and historical features of health care systems. Political economy criticisms such as these emerged in the 1960s and have continued with increasing vigor into the present, producing a growing body of scholarship.

I will be describing more recent developments in the critical studies of biomedicine later in this chapter. However, it is not simply the critique of our own forms of healing through glimpsing ourselves in the mirror of the other, nor criticisms of the political economy of health that gives vitality to medical anthropology. Criticism of medicine, whatever form it takes, is nearly always linked for North American anthropologists to a commitment to helping bring the benefits of public health and medical services to non-Western societies or to cultural minorities and the poor in our own society. The duality of the anthropologist's role as critic and participant has provided an ironic cast to that commitment. Foucault's analyses of medicine and psychiatry as primary "disciplinary" institutions in modern society, as agencies which extend surveillance and control of the state into the most intimate domains of life, stand in stark contrast to the evident need for the most basic health services in much of the world. Sociological critiques of the doctor–patient relationship, and feminist accounts of how medical knowledge encodes dominant significations of gender and of women, stand side by side with accounts of terrible and needless maternal mortality in many societies, of deaths

which could easily be prevented by extending health services. Historical and cultural analyses of tuberculosis, cancer, schizophrenia, venereal diseases, and AIDS all reveal both dramatic advances in knowledge and therapeutic efficacy and an encoding of dominant cultural ideologies at the core of medicine and its practices. Critical analyses of medicine and its reproduction of dominant power relations are thus often juxtaposed uneasily with anthropologists' commitment to extending the presence and benefits of medicine and efforts to promote humane practice. This juxtaposition and the dual role of many anthropologists as critics of and committed participants in the work of medicine provide a special quality to medical anthropology's cultural critique.

Debates concerning how to write about and analyze the "illness representations" of others, however, reflect not only an ambivalence about the extension of medicine's power and the anthropologist's contribution to that process, but an underlying epistemological ambivalence as well. Any analysis of local medical culture – of the illness representations of individuals or the forms of medical knowledge of a given society or subculture or therapeutic tradition – requires the anthropologist to take an epistemological stance concerning the knowledge claims made by our informants. This forces medical anthropologists to deal with difficult questions implicit in the choice of analytic strategy. How do we represent the claims to knowledge of healers in another society, given the authority of biomedical knowledge? How do we situate our analyses of diverse traditions of medical knowledge and practice – of Ayurveda in India or traditional Chinese medicine, or African ritual traditions of healing, or that of Catholic charismatics in North America – in relation to medicine? How do we maintain a conviction that popular medical cultures represent genuine local knowledge, given the corrosive authority of biomedical science and the obvious efficacy of its preventive and therapeutic measures? The issue is not simply that of the "efficacy of traditional healing." Questions of the efficacy of clinical medicine, especially as practiced in much of the world, are often quite distinct from the truth claims of biomedical science, and the same is even more true for other forms of healing. The question is rather how we situate our analyses of cultural representations of illness, encoded in popular or folk therapeutic traditions or in individual understandings and practices, in relation to the truth claims of biomedicine.

These epistemological questions point further to a series of empirical and theoretical questions about the relation of culture and illness. How do we conceptualize illness as the object of cross-cultural research? To what extent is it to be considered "external to culture," an object in the natural world about which peoples have more or less correct representations, "beliefs" that contrast with empirical knowledge? To what extent is "disease," in Kleinman's early definition of the term, distinct from "illness"? Is cultural representation a part of the object itself, biology cultural at its core, and what specifically would such a claim entail? How are social relations manifest and reproduced in illness representations and disease itself? How do we write analytically about the extremely diverse representations of illness in popular culture, specialized therapeutic traditions, and

medical science? And how do we frame programs of research for the field consistent with our views on these issues?

Responses to questions such as these, to what I described in the first chapter as the contradictions between the historicist perspective of anthropology and the universalist claims of biomedical science, and more generally to the problem of how we analyze cultural representations of social and biological "objects," have provided a special theoretical vitality to current debates in medical anthropology. In this chapter I reflect on the history of medical anthropology, in particular anthropology's analysis of illness representations and the emergence of something akin to paradigmatic disputes within medical anthropology during the past decade, as a venue for taking stock of such issues. A discussion of the primary theoretical frames that have been articulated may bring into focus issues that provide the impetus for the constructive chapters of this book.

Epistemological claims in early studies of illness representations: rationalist and relativist theories

The earliest anthropological writings on culture and medicine share much of the embarrassing evolutionary language of other parts of the field. Conventional histories of medical anthropology (for example Wellin 1977) outline a heritage that includes the writing of W. H. R. Rivers, Forrest Clements, historian Erwin Ackerknecht, and others for whom terms like "primitive," "magical," "mystical," "pre-logical," "proto-scientific," and "folk" are all common adjectives for "medical beliefs" among "natives." For those who wrote within what I have called the empiricist tradition, especially British intellectualist writers, illness representations could be ranked according to a hierarchy of increasing rationality. Through the 1940s, medical beliefs and practices of non-Western peoples were often interpreted as early stages of medical knowledge, a kind of proto-science elaborated in primitive theories of disease causation, primitive surgical practices, and primitive knowledge of pharmacological properties of plants and minerals. The historical evolution of human knowledge, whether from magic to religion to science, as Rivers argued, or from primitive or proto-scientific theories of disease causation to those of contemporary biomedicine, served as the frame for contrasting primitive or folk beliefs with scientific knowledge. Clements' monograph, *Primitive Concepts of Disease* (1932), followed an extreme "culture-trait" approach: a classification of five theories of disease causation was provided (sorcery, breach of taboo, intrusion by a disease object, intrusion by a spirit, and soul loss), and the geographical and historic distribution of these cultural elements was mapped (cf. Wellin 1977: 50–51). Ackerknecht, a physician and historian who acknowledged the influence of the British functionalists as well as Ruth Benedict, rejected any analysis of trait distribution. Medicine is a cultural configuration, he held, a functionally integrated system of cultural beliefs and practices, and must be analyzed within cultural context. Nonetheless, Ackerknecht held firm to his empiricist convictions. Medical categories such as

"surgery" or the "autopsy" served as the basis for historical comparisons, and Ackerknecht held that primitive medicine as a system "is primarily magico-religious, utilizing a few rational elements, while [our modern-Western] medicine is predominantly rational and scientific employing a few magic elements" (1946: 467; quoted in Wellin 1977: 52). Identifying the empirical knowledge (its "rational elements") in such primitive systems, characterizing "beliefs" about disease causation and treatment, and providing a history of the emergence from primitive medicine of more accurate representations of the natural world of disease thus served as the larger research program. Although the "modern medicine" contemporary to these writers was characterized as a social and cultural institution, thus contributing to a later sociology of medicine, the scientific understandings of disease which were current for these writers served to distinguish the primitive from the modern and belief from knowledge.

Quite independent of later critiques of evolutionary and colonialist aspects of the analytic language employed, however, elements of what I have described as an "epistemological ambivalence" were present even in this early work. In particular, the analysis of a society's medical beliefs and activities as an integrated body of ideas and a coherent social institution raised serious questions for the identification of isolated rational or proto-scientific elements embedded within a primarily magico-religious system. An example from the physician anthropologist W. H. R. Rivers will illustrate. In a short paper read at the Seventeenth International Congress of Medicine in London on August 7, 1913, Rivers (1913: 39–42) described his observation of a native practitioner on the Solomon Islands (where he was a member of the Percy Sladen Trust Expedition) who provided "abdominal massage" which was carried out "so far as I could tell, just as it would have been by a European expert."

> On questioning the woman who was the subject of the treatment, it seemed that she was suffering from chronic constipation, and if the matter had not been gone into more fully, it might have been supposed that the Solomon Islanders treated this disease according to the most modern scientific therapeutics. Further inquiries, however, brought out the fact that the manipulations we had observed had had as their object the destruction of an octopus which, according to the native pathology, was the cause of the woman's troubles. She was held to be suffering from a disease called *nggaseri* caused by the presence of an octopus in the body. On inquiring into prognosis, we were told of a belief that the tentacles of the octopus tended to pass upwards and that, when they reached the head of the patient, a fatal result ensued. The object of the treatment was to kill the octopus, and in the case we observed treatment had already been carried out for several days, and the octopus, which had at first been very large, had now become small and was expected soon to disappear altogether. This result, however, was not ascribed so much to the mechanical action of the manipulations as to the formulae and other features of the treatment which accompanied the passage. (Rivers 1913: 39)

Rivers went on to indicate the questions raised by this case for his analysis.

> A few years ago I should have had no hesitation in regarding this Melanesian practice as an example of the growth of a rational therapeutic measure out of a magical or religious rite. I should have supposed that these practices of the Solomon Islanders were designed originally to extract the octopus . . . from the body, and that it would only be necessary to slough off what we regard as the superstitious aspect of the practice to have a true therapeutical measure. I should have regarded the Melanesian practice as one which has preserved for us a stage in the process of evolution whereby medicine evolved out of magic, and as a matter of fact, I believe that the vast majority of my anthropological colleagues, at any rate in this country, would still be fully satisfied with this view. Many students of anthropology, however, are now coming to see that human institutions have not had so simple a history as this view implies . . . (Rivers 1913: 40)

As he proceeds with his brief analysis, Rivers does not spell out the obvious question facing the cross-cultural researcher – whether he was observing "massage" at all, whether an activity understood in so different terms by its practitioners can be analyzed as an early version of "the true therapeutical practice," that is, the practice of British massage therapists of Rivers' day. Rivers instead raises the hypothesis of historical diffusion of this practice as an alternative to his usual evolutionary formulation. Nonetheless, in this small piece, he acknowledges the difficulties with "so simple a history," that is with projecting the relation of belief to knowledge backwards into evolutionary history, and calls for a recovery of the actual history of ideas. Along with Ackerknecht, he recognizes that any given idea or practice has meaning in relation to medicine conceived as a larger "social institution" (1913: 41) and that this poses serious problems for the very definition of terms of analysis. Thus, even among the classic empiricist writers, difficulties with using contemporary categories of disease or therapeutic practice as the basis for investigating variations in cultural beliefs were recognized.

The primary alternative to the empiricist writers of the first half of this century was developed by American anthropologists in the Boasian tradition. Interestingly, the data that served as the basis for a relativist alternative were drawn from psychiatry rather than from infectious diseases and medical or surgical interventions – a pattern that has continued in much anthropological writing to the present. In a small paper entitled "Anthropology and the Abnormal," published in the *Journal of General Psychology* (1934), Ruth Benedict elaborated a critique of current theories of psychopathology. In particular, she sought to show that "confusion" follows from viewing psychological abnormality in terms of "social inadequacy" or in relation to "definite fixed symptoms" (p. 76), rather than in relation to a culture's values and definitions of normalcy. The essay begins with the observation that anthropological studies show that "mannerisms like the ways of showing anger, or joy, or grief in any society," or "major human drives like those of sex" "prove to be far more variable than experience in any one culture would suggest." This finding raises difficulties for "the customary modern normal–abnormal categories and our conclusions regarding them" (p. 59). Indeed, she argues, "it does not matter what kind of 'abnormality' we choose for illustration, those which indicate extreme instability, or those which are more in the nature of character traits like sadism or delusions of grandeur or of

persecution, there are well-described cultures in which these abnormals function at ease and with honor, and apparently without danger or difficulty to the society" (p. 60). Benedict then provides a series of examples – of "trance and catalepsy" developed among shamans, of homosexuality as a "major means to the good life" in Plato's *Republic*, and of quite dramatic cases in which "an abnormality of our culture is the cornerstone of their social structure." Civilizations thus select from among "the whole potential range of human behavior" some forms of personality, some modes of behavior and experience, which they idealize and stamp with the approval of morality, while others are viewed as abnormal, deviant, or immoral. From this she drew conclusions that have continued to be influential in psychological anthropology and cross-cultural psychiatry:

> Most of those organizations of personality that seem to us most incontrovertibly abnormal have been used by different civilizations in the very foundations of their institutional life. Conversely the most valued traits of our normal individuals have been looked on in differently organized cultures as aberrant. . . . The very eyes with which we see the problem are conditioned by the long traditional habits of our own society. (Benedict 1934: 73)

Problems of social functioning are thus not the sources but the result of definitions of abnormality, and "symptoms" are both defined as such and culturally elaborated as forms of behavior available to "unstable individuals."

Benedict's claim here went beyond the general argument that cultural conventions define forms of emotional expression or behavior or personality types as normal or abnormal. Within the tradition of Boasian anthropology, Benedict was responding to positivist psychology of the day with the argument that psychopathology or psychiatric disease is constituted in cultural forms that can only be interpreted in relation to the larger cultural pattern of a particular society. Boasian anthropology, as Stocking (1968) has shown, was closely related to the German historicist writing of the late nineteenth and early twentieth centuries, with its criticisms of positivism in both the human and natural sciences, its interests in subjective culture, and its concern with historically emergent cultural configurations, holism, vitalism and systems theory.[2] Viewed from the perspective of this intellectual tradition, Benedict was articulating several claims about the nature of psychopathology. First, psychological distress is a form of social reality specific to a particular culture and language, not simply a disease or cluster of symptoms or psychological deficit interpreted in local terms. Psychiatric illness cannot be separated from a particular cultural context, and is therefore subject to Sapir's classic comments on the nature of social reality:

> . . . the "real world" is to a large extent unconsciously built up on the language habits of the group. No two languages are ever sufficiently similar to be considered as representing the same social reality. The worlds in which different societies live are distinct worlds, not merely the same world with different labels attached. (Sapir 1949 [1929]: 69)

Sapir differed with Benedict on several points. He held that the "true locus of

culture" is to be found in "the interactions of specific individuals and, on the subjective side, in the world of meanings which each one of these individuals may unconsciously abstract for himself from his participation in these interactions" (Sapir 1949 [1932]: 515), rather than in "society."[3] And he down-played the tyranny of normalcy as a primary cause of maladjustment and pathology.[4] However, Benedict's formulation of psychiatric illness as a culturally specific form of reality, rather than a set of universal diseases "with different labels attached," is consistent with Sapir's overall position and with the historicist critique of positivist psychology.

Second, Benedict was making the more specific point that any social institution or behavior cannot be interpreted as an isolable trait, but only in relation to a cultural configuration. Elsewhere she indicated one source of her theories when she commented explicitly upon the *Gestalt* psychologists' writings about the need to study sense-perception in relation to "the subjective framework" and the "wholeness properties" rather than as "objective fragments." "The whole determines its parts, not only their relation but their very nature. Between two wholes there is a discontinuity in kind, and any understanding must take into account their different natures, over and above a recognition of the similar elements that have entered into the two" (Benedict 1934: 57). Her 1923 dissertation on the Guardian Spirit trait in American Indian cultures concluded that this "trait" became a fundamentally different cultural object when it entered into a particular cultural *Gestalt*, and she carried this conviction to her analysis of all forms of behavior, including abnormality or psychopathology.

Third, Benedict was arguing that normality and abnormality are ethical concepts, variants of "the concept of the good" (p. 73). And as "we do not any longer make the mistake of deriving the morality of our own locality and decade directly from the inevitable constitution of human nature," so we should also recognize the essential relativity of concepts of abnormality. Benedict drew her reflections on these issues to a close with a specific hypothesis.

> The categories of borderline behavior which we derive from the study of the neuroses and psychoses of our civilization are categories of prevailing local types of instability. They give much information about the stresses and strains of Western civilization, but no final picture of inevitable human behavior. Any conclusions about such behavior must await the collection by trained observers of psychiatric data from other cultures. . . . It is as it is in ethics: all our local conventions of moral behavior and of immoral are without absolute validity, and yet it is quite possible that a modicum of what is considered right and what wrong could be disentangled that is shared by the whole human race. When data are available in psychiatry, this minimum definition of abnormal human tendencies will be probably quite unlike our culturally conditioned, highly elaborated psychoses such as those that are described, for instance, under the terms of schizophrenia and manic-depressive. (Benedict 1934: 79)

This hypothesis has served to orient a lively research literature that continues in medical and psychiatric anthropology and cross-cultural psychiatry to this day. One line of discussion elaborated Benedict's argument that the shamans of many

societies would be considered seriously disordered in our own society.[5] A small set of papers argued that shamans are persons suffering schizophrenia but are in a cultural environment which provides them validation and a meaningful role. These papers often use the term "schizophrenia" in a quite confused way, and the hypothesis has been largely abandoned. Others, however, have followed her lead in exploring the cultural elaboration of trance and possession, and with the new interest in "dissociation" in American psychiatry, the study of the relation of these to pathologies of dissociation in our own society is once again quite active.[6]

A second line of empirical research has investigated the extent to which psychopathology varies across cultures. On the one hand, under the broad rubric of "culture-bound disorders," some have explored Benedict's hypothesis that societies develop quite specific and highly elaborated forms of psychopathology.[7] On the other, a set of studies have investigated variations in the phenomenology and course of schizophrenia, depression, manic-depressive illness, and anxiety disorders.[8] A third line of discussion and research has extended Benedict's hypothesis that each culture labels some forms of behavior as deviant and treats these as illness, and that such labelling has important consequences for those so identified. Early forms of the "social labeling" hypothesis treated the Soviet incarceration of political dissidents under the label "schizophrenic" as a prototype for all mental illness, and were rightly rejected. However, "social response" theorists have developed an extremely important literature on how society's institutionalized responses to "primary deviance" (including, for example, an initial psychotic episode) are crucial in shaping the life course of sufferers and the course and prognosis of psychopathology. Indeed, studies of the role of social and cultural processes in determining whether an episode of major mental illness will become chronic and deeply debilitating are some of the most important in psychiatric anthropology and social psychiatry today.[9]

Benedict's initial formulation has thus been followed by an extremely productive program of theorizing and empirical research, and the "collection by trained observers of psychiatric data from other cultures" has proceeded much further apace than in many areas in the field. For purposes of examining the history of theorizing about culture and illness representations, however, several points are worth noting. Benedict and those who have followed her lead have developed an alternative form of cultural critique to that provided in the rationalist tradition. Her response to positivist psychologists was not simply that they and their medical colleagues have failed to understand cultural beliefs that motivate behavior, beliefs which are coherent and rational in their own way. (Benedict used the term "belief" in her 1934 essay only once [p. 59], and that to refer to our own "false sense of the inevitability" of "custom and belief" that has become standardized across two continents.) Her challenge was more fundamental. Illness is relative to the cultural and ethical forms of a particular society. Any truly scientific psychology must recognize the cultural relativity of pathology, rather than simply assume that our own illness forms are part of human nature and therefore universal. Embedded in this formulation was the claim that

illness representations or understandings of abnormality are not simply more or less accurate theories of a phenomenon external to culture, but that such representations constitute the very phenomenon itself. Pathology is an essentially cultural object, in this formulation, and representations are part of the very essence of the object. It is this basic formulation that sets off these early relativist writings from their rationalist counterparts.

There were, however, problems in Benedict's formulation that have continued to confuse discussions in medical and psychiatric anthropology. Benedict's hypotheses about the extent of cultural variation in the "neuroses and psychoses," in particular for those described "under the terms of schizophrenia and manic-depressive," have not stood up to empirical investigation. In particular, her argument that even the psychoses are part of the arc of human behavior that is considered normal and is valued highly in some societies, confuses "temperament" – characteristics such as individualism or aggressiveness or suspiciousness – with major pathology, and discounts the severity of major mental illness and the devastation it wreaks in the lives of individuals and families. Her understanding of psychopathology as essentially a problem of "adjustment," which reflected theorizing of her day, no longer seems tenable. Furthermore, while her use of psychiatric labels such as "paranoid" and "megalomaniac" to characterize whole cultures was intended to indicate that our own labels for pathology are culture-bound and relative, her rhetorical move led to an essential pathologizing of the cultures about which she wrote. Terms derived from clinical descriptions of individuals were applied to societies, producing enormous difficulties that emerged in the culture and personality literature and discredited much of the work of psychological anthropologists.

In spite of these basic difficulties, Benedict's formulation of the cultural mapping of the "borderline" between the normal and abnormal, her discussion of the power of social response to amplify pathology, and her basic contention that abnormality and pathology are inseparable from cultural interpretation continue to have relevance for many of the issues in our field. And her fundamental claim that pathology itself is inseparable from culture is one which continues to challenge empiricist theories about the relation of cultural representation and disease.

The juxtaposition of early rationalist and relativist writings in anthropology, typified by the British intellectualist Rivers and the American cultural anthropologist Benedict, highlights a faultline that runs through the literature on culture and illness, a faultline in epistemological stance, in form of cultural critique of medicine, and in overall conceptions of a program for anthropological studies of illness. Understanding the history of these positions clarifies what is at stake in many of the debates in the field and provides a foundation for theoretical and methodological discussions which will follow. An uncritical description of the field in these terms, however, would serve to perpetuate some of the least enlightening debates in medical, psychiatric and psychological anthropology. In particular, the juxtaposition of the analysis of psychopathology in relativist terms – as culturally defined abnormality, with culture-bound disorders as the prototype

– over against the analysis of "medical" disorders, in particular infectious diseases, in rationalist terms has served the field poorly (see B. Good 1992b for a fuller discussion). Although these positions are still evident in writing and research, this division of the field no longer accords with what we know about psychiatric, infectious, or chronic medical disorders. It also no longer represents the primary theoretical positions that have evolved in the field since the early 1970s. And as I discussed in the first chapter, the stark juxtaposition of rationalism and relativism no longer maps the important epistemological positions in anthropology, philosophy, or the sociology of science, though they continue to be evoked in arguments.

In the remainder of this chapter, I will outline four theoretical positions that have evolved in the field, in particular since the late 1970s, provoking lively and at times heated debates. My goal is by no means a complete review of the field. It is rather to use the rubric "illness representations" to draw attention to epistemological presuppositions implicit in and often hidden by these debates. Reflections on these issues will lay the ground for the chapters that follow.

Current debates concerning illness representations: four orienting approaches in medical anthropology

Reviews in the *Biennial* (and *Annual*) *Review of Anthropology* by Scotch in 1963, Fabrega in 1972, and Colson and Selby in 1974 map the emergence by the early 1970s of a growing literature on "ethnomedicine" and of research in "medical ecology and epidemiology." Less than a decade later, Allan Young (1982) remarked in the *Annual Review of Anthropology* on the enormous growth in the field in the few intervening years – on the appearance of specialized collections, anthologies, theoretical works, ethnographies, textbooks, book series, and new journals. He then provided a reading of theoretical developments in the field during these years. The flourishing of academic work resulted from a decade of studies of "medical systems," which produced a growing body of ethnographic data on the complex forms of medical knowledge and therapeutic traditions in much of the world.[10] It also reflects the beginnings of an extraordinary specialization within medical anthropology, and the development of a theoretical literature articulating an autonomous anthropological account of illness, therapeutics, and medical knowledge.

The development of medical anthropology as a domain of anthropological theorizing during these years is especially noteworthy. Kleinman's *Patients and Healers in the Context of Culture* (1980), coupled with the publication of the new journal *Culture, Medicine and Psychiatry* beginning in 1977, marked a coming of age of theorizing in medical anthropology, and writing in the field became increasingly explicit about the philosophical and methodological issues at stake. Thus, when Young reviewed the field in 1982, he could write a critical account of theoretical positions that had developed in the previous decade. This represented a qualitative change in the status of the field.

Quickly setting aside approaches originally developed for analysis of other domains (such as religion and ritual) and those borrowing methodological and conceptual categories from the largely positivist medical behavioral sciences, Young outlined an emerging theoretical distinction between what he called an "anthropology of illness" and an "anthropology of sickness." He provided a critical reading of what he labeled "the explanatory model of illness approach" and called for elaboration of an alternative position "which gives primacy to the social relations which produce the forms and distributions of sickness in society" (1982: 268). Although I believe that in labeling meaning-centered analyses "EM theorizing" Young seriously misrepresented that tradition, his paper contributed to the emergence of clearly articulated theoretical positions in the field. His review both acknowledged the emergence of a rich theoretical discourse in medical anthropology and helped advance a critical analysis of the concepts and strategies employed.

Given the growth of the field, it is no longer possible to provide a review of the whole field in a single essay or chapter.[11] It is even impossible in the space of a few pages to provide a full account of the theoretical developments of the past decade. A brief discussion of four approaches to the study of "illness representations," however, may help make sense of the problems we face in developing a genuinely anthropological account of illness and provide an assessment of current debates about the nature of medical knowledge. In particular, comparison of the place of language in each of these "paradigms" and of the vision of a program for medical anthropology implicit in each reveals significant differences in epistemological stance and in the conception of comparative studies.

Illness representations as folk beliefs: the persistence of the empiricist tradition

The medical behavioral sciences – medical psychology, the sociology of illness behavior, applied behavioral sciences in public health, epidemiology – have been important features of North American medical research and education for several decades, and have grown rapidly over the past fifteen years, contributing to the criticism of what is broadly referred to as "the medical model." In large measure, however, these writings rely on belief and behavior models firmly rooted in a positivist or empiricist paradigm which they share with biomedicine. The language of belief is ubiquitous, and although biomedicine is criticized for its failure to attend to social and psychological variables, medical knowledge is largely assumed to be normative. The individual actor – subject to environmental stresses, site of disease, source of rational and irrational illness behavior – is analytically primary. And applications are largely directed at educating individuals to modify irrational behavior – to reduce risk factors, comply with medical regimens, seek care appropriately.

Throughout its history, medical anthropology has engaged in a critique not only of biomedicine but of the positivist medical behavioral sciences as well. Responses to illness that differ from that assumed rational from the physician's

point of view are not simply the result of lack of information or "superstitions," anthropologists have argued. They are grounded in culture, a system of beliefs and practices which however variant from biomedicine has its own logical structure – a cultural logic – and serves adaptive functions that often go unnoticed. Thus culture is asserted as a central feature of human response to illness, a feature largely ignored by the medical behavioral sciences, and this assertion has served as the source of a wide-ranging anthropological critique.

In labeling this section "The persistence of the empiricist tradition," I mean to suggest that in spite of the criticism of the medical behavioral sciences, a strong current of anthropological theorizing continues to reproduce much of the underlying epistemological framework of the biosciences. I have argued that the rationalist tradition, represented by W. H. R. Rivers, had a powerful presence in medical anthropology. Although they criticized naive public health specialists, applied medical anthropologists of the 1950s drew on a language of belief and behavior that placed them clearly within this tradition. Since the mid-1970s, applied work in medical anthropology has become far more specialized than could have been imagined by the pioneers in this area, and some of the most interesting and critical writing has come from those engaged directly in international health settings. My argument, however, is that important elements of the empiricist paradigm continue to exert great influence in the field. They are present in the common-sense view of medical anthropology as the study of beliefs and practices associated with illness by persons from diverse cultures, as well as in the models used to facilitate collaboration among anthropologists, clinicians, epidemiologists, and others in applied settings. They are present subtly in studies of lay health beliefs and care-seeking. And they have been articulated quite explicitly in recent formulations of medical anthropology in "biocultural" or "ecological" terms. It is my goal here to summarize three of the key elements in the empiricist paradigm and to outline a critique that opens to newer directions in the field.

There is a danger that some may read my analysis and critique of the current empiricist paradigm in medical anthropology as a criticism of applied or multidisciplinary work in the health sciences or of studies that take biology and ecology seriously. Others may feel that discussions of theory are largely irrelevant to such work. Let me be clear. I am by no means equating anthropology applied to clinical or public health settings with the empiricist tradition or any other; fortunately, excellent work, drawing on quite diverse traditions, is being done in such settings.[12] And I agree with Rubel, who has long argued (for example, Rubel and Hass 1990: 119) that we need to turn from "mentalistic" studies of folk illnesses to research that incorporates an understanding of biology and focuses on major health problems of populations. My contention, however, is that the theoretical difficulties of the empiricist paradigm have extremely important implications for research as well as for efforts to apply our insights in health care settings. Analysis of these difficulties is thus relevant to our understanding of the relation of biology and culture, to methodological discussions, and to practical work in clinical settings, health education, and international public health.

What I am calling here the common-sense or empiricist approach in the medical social sciences has three essential elements: the analysis of illness representations as health beliefs, a view of culture as adaptation, and an analytic primacy of the rational, value-maximizing individual. It is my argument that taken together these constitute a form of "utility theory," in Sahlins' (1976a) terms, which reproduces conventional understandings of society even while introducing culture into the medical paradigm.

First, the analysis of culture as "belief" figures prominently not only in the medical behavioral sciences, but in much of medical anthropology as well. From research and interventions based in the "Health Belief Model," developed by social psychologists working with public health specialists in the 1950s, to the sociology of "lay health beliefs" to anthropological studies of ethnomedicine, classically defined as "those beliefs and practices relating to disease which are the products of indigenous cultural development" (Hughes 1968), "belief" serves as an unexamined proxy for "culture." While all anthropologists today find Rivers' colonialist language offensive, it is still common to find his formulation of the field prominently quoted:

> The practices of these peoples in relation to disease are not a medley of disconnected and meaningless customs, but are inspired by definite ideas concerning the causation of disease. Their modes of treatment follow directly from their ideas concerning etiology and pathology. From our modern standpoint we are able to see that these ideas are wrong. But the important point is that, however wrong may be the beliefs of the Papuan and Melanesian concerning the causation of disease, their practices are a logical consequence of those beliefs. (W. H. R. Rivers 1924 [quoted, for example, in Welsch 1983: 32])[13]

It seems almost natural that a section on culture and medicine in a new undergraduate textbook on applied anthropology (*Applying Cultural Anthropology*, written by Podolefsky and Brown [1991]) would be entitled "Belief, Ritual, and Curing," even though analysis of beliefs has little place in the four essays in this section and none of the other ten sections of the book bear the label belief in their titles.

"Belief" typically marks the boundaries between lay or popular medical culture and scientific knowledge, as I discussed in the first chapter. To take examples almost at random, a recent public health study of "knowledge regarding AIDS" in Kinshasa, Zaire, summarized its findings as follows:

> Awareness of AIDS is almost universal, and the vast majority *know* the four main modes of transmission. Almost half *believed* in transmission by mosquitoes and in a vaccine or cure for AIDS. The majority of male respondents *knew* of condoms, but negative attitudes toward condom use are widespread, and few respondents perceived them to play a central role in combatting AIDS. (Bertrand et al. 1991; emphasis added)[14]

The findings from this research are potentially quite important. However, as formulated in this report, lay beliefs are false propositions, juxtaposed to medical

knowledge, and the clear implication is that correcting false beliefs is a first priority of public health.

Or again, in a quite good ethnographic account of the response of local people on a Papua New Guinea island to the opening of a government first aid post, Lepowsky (1990: 1049) poses the question for her research as follows: "What happens when Western medicine is introduced to people who believe that virtually all serious illness and death are due to sorcery, witchcraft or taboo violation?" She goes on to describe the "belief system" on Vanatinai, juxtaposing the medicine of the aid post orderly with that of traditional beliefs, and shows that even when credit is given to the efficacy of penicillin, people stressed "the supernatural potency of my American pills," and "the belief in the personal and supernatural causation of this life-threatening illness (by sorcery) had remained the same" (p. 1059).[15] In these and many other studies, traditional medical culture is routinely analyzed as a set of beliefs, explicitly or implicitly juxtaposed to medical knowledge, and a central question for the research is how "traditional medical beliefs" (which are obviously false) can hold out in the face of biomedicine's efficacy and claims to rationality.

Analyses of traditional medicine as belief systems, such as these, are often linked quite closely to a second element in the empiricist paradigm, a view of "medical systems as sociocultural adaptive strategies," as Foster and Anderson subtitled their chapter on medical systems (1978: 33). While few would accept the explicit and sometimes crudely stated functionalism of this book today, their view of medical systems as adaptive is often unchallenged. They write: "just as we can speak of biological adaptive strategies that underlie human evolution, so too can we speak of *sociocultural adaptive strategies that bring into being medical systems*, the culturally based behavior and belief forms that arise in response to the threats posed by disease" (p. 33; emphasis added).

Medical anthropology was formulated in terms of human ecology and biological adaptation by Alland in an influential paper in the *American Anthropologist* in 1966 and in a monograph in 1970.[16] This formulation served as a response to a narrow rendering of ethnomedicine in cognitive terms, that is as folk beliefs, and placed studies of medical systems in a dialogue with a growing literature on human biology, social ecology, the history of infectious diseases, and the epidemiological consequences of particular behaviors. It thus brought biology more clearly into medical anthropology.

Ironically, the ecological paradigm reproduces the view of ethnomedicine as belief system which it set out to criticize. Alland outlined the program for the ecological approach explicitly within the evolutionary models of cultural ecology, in particular the neofunctionalist theories of Vayda and Rappaport, and many of the "biocultural" approaches in medical anthropology accept this framework uncritically. For example, in their text *Medical Anthropology in Ecological Perspective*, McElroy and Townsend (1985) distinguish genetic adaptations, individual physiological adaptations through a life course, and "the use of cultural information shared by a social group and transmitted through learning to each

generation" (p. 73). These "cultural customs, beliefs, and taboos," which constitute the medical system, have direct as well as unintended adaptive effects. Traditional medical "beliefs and behaviors" are thus analyzed as cultural traits that enhance a population's adaptation to their ecological environment.[17] Culture, from this perspective, is conceived as a set of adaptive responses to diseases, which are here interpreted as analytically prior to and independent of culture, and medical systems are the sum or result of cumulative individual strategic responses, "strategies that bring into being medical systems" (Foster and Anderson 1978: 33).[18]

Analysis of specific forms of illness behavior which give theoretical primacy to individuals and to their adaptive "strategies" or "choices" constitutes a third element of the rationalist paradigm in the medical behavioral sciences. Paradigmatic of this approach have been studies of care-seeking strategies. Early anthropological studies of care-seeking drew on the medical sociology literature on "illness behavior" and the "lay referral system" (Freidson 1961, 1970), as well as on the social psychology literature on the Health Belief Model. All were a response, in a sense, to naive medical and public health questions about why people do not go to the doctor (as they obviously should) when they get sick. A brief examination of the health belief and illness behavior models provides a clear indication of the assumptions of the rationalist paradigm.[19]

The Health Belief Model (HBM) was developed in the 1950s by a group of social psychologists influenced by Kurt Lewin, in response to efforts by members of the Public Health Service to increase utilization of widely available preventive measures for diseases such as tuberculosis – and later, rheumatic fever, polio, and influenza (Rosenstock 1974). In close accordance with various behaviorist theories of motivation and decision making, the model predicted that behavior depends largely upon the value placed by the individual on a particular goal, and upon the individual's estimate of the likelihood of an action resulting in the goal (Maiman and Becker 1974). More specifically, the model hypothesized that perceived susceptibility to a disease and perceived severity of that disease, combined with perceived benefits of preventive actions minus perceived barriers to taking those actions, explained the likelihood of an individual taking preventive health measures, complying with prescribed regimens, or utilizing medical services.

In spite of continued reliance on HBM theories in health education, the leading figures of this field, Janz and Becker, concluded their 1984 review with a pessimistic evaluation of the approach: "Given the numerous survey-research findings of the HBM now available, it is unlikely that additional work of this type will yield important new information" (p. 45). Why was this the case? Why has HBM research failed to cast light on the most significant cultural differences in illness behavior and rates of morbidity and mortality? In part, I believe, its limitations result from the HBM's narrow conception of culture and human action.

The theory of culture assumed by HBM researchers has two characteristics.

First, HBM theories are explicit versions of what Sahlins (1976a: 101–102) calls "subjective utilitarianism." Its actor is a universal Economic Man, proceeding rationally toward the goal of positive health, a preference only slightly modified by health beliefs. Actors weigh the costs and benefits of particular behaviors, engaging in a kind of "threat-benefit analysis," then act freely on their perceptions to maximize their capital. As Sahlins notes, in such utilitarian theories culture is "taken as an environment or means at the disposition of the 'manipulating individual,' and also a sedimented result of his self-interested actions" (1976a: 102). Although purportedly Lewinian in its focus on the perceptions of individuals, the theory analyzes the structure of health beliefs and thus health culture only to the extent that they contribute to the rational calculus of the care-seeker who is ultimately free to make voluntary choices.

Second, HBM theories have a narrow and classically empiricist theory of culture as health beliefs. Developed specifically to help public health specialists convince people to act more rationally – to use preventive services, obey doctors' orders, or utilize medical services "appropriately" – such theories evaluate health beliefs for their proximity to empirically correct knowledge concerning the seriousness of particular disorders or the efficacy of particular behaviors or therapies. The wealth of meanings associated with illness in local cultures is thus reduced to a set of propositions held by individual actors, which are in turn evaluated in relation to biomedical knowledge.

The Health Belief Model thus presumes a quite explicit theory of culture. Lay medical culture is the precipitate of rational, adaptive behaviors of individuals, and it takes the form of more or less accurate beliefs which are held in individual minds. Thus, in the HBM research, the analysis of culture is made doubly subservient, relativized to the privileged perspective of current medical knowledge, and placed in the service of a utilitarian theory of illness behavior.

A second example is closer to much anthropological work. David Mechanic (1982: 1; cf. Mechanic 1986) outlines a basic model of illness behavior that could easily be translated into a research program current in much of medical anthropology.

> Illness behavior . . . describes the manner in which persons monitor their bodies, define and interpret their symptoms, take remedial actions, and utilize the health care system. People differentially perceive, evaluate, and respond to illness, and such behaviors have enormous influence on the extent to which illness interferes with usual life routines, the chronicity of the condition, the attainment of appropriate care, and the co-operation of the patient in the treatment of the condition.

This model holds, essentially, that the individual experiences bodily sensations, appraises these (or makes illness attributions) using available illness representations (or explanatory models), then makes treatment choices in consultation with members of a lay referral network. It would seem that this model is reasonably value-free and could accommodate and highlight differences among cultures. But is this the case?

In a study by Lin and his colleagues (1978), which examined care-seeking pathways followed to mental health services by Anglo, Chinese, and American Indian patients in Vancouver, only one of the three ethnic groups studied fit easily in this model. Individuals from the Anglo-Saxon and middle European sample experienced symptoms, consulted family members, reviewed available resources, and chose mental health or social service resources, following a pattern very close to that outlined by the illness behavior model. The two other groups studied, however, fit the model less easily. For the ethnic Chinese, there were early and prolonged efforts by the family to manage problems in each episode without encouraging the sufferer to seek professional care. Many were isolated in the home and allowed few contacts. Remarkably advanced psychiatric symptoms were often present before any outside care was sought. Medical interventions eventually occurred, although involvement with legal and social agencies was rare. Clearly, the sick individual was not the source of decision making, and the family was much more than a "lay referral network." Indeed those who are sick have little freedom of action, and the family organizes the entire care-seeking and therapy management, which often consists largely of seclusion. The American Indian patients, however, were even further from the seemingly neutral model of illness behavior. These patients were most commonly found among Vancouver's homeless mentally ill, with neither a family to organize care-seeking choices, nor the ability to actively organize their own care. They were often transferred between social service agencies and police, who became the major groups responsible for "care-seeking decisions" rather than the patients themselves.

This study raises significant questions about what may seem to be the most culturally-sensitive models of the medical behavioral sciences. The ability of the individual to appraise symptoms, review available resources, then make voluntary choices is simply a myth for many in our society and in other societies. The model of the rational, autonomous care-seeker (or even the therapy management group) organizing treatment choices to maximize perceived benefits to the sufferer is hardly a value-free model. It is rather a model of how members of our society are thought to act, an ideological model which reproduces conventional understandings and serves best when used to study middle-class Americans who have health insurance and are seeking care for relatively minor problems. When the sampling domain is adequately delimited, the illness behavior model (as the health belief model) accounts for much of the variance in care-seeking behavior. It does tell us why some people choose to seek care for some problems, not others. However, it does so only by excluding those persons who have the least control over their lives, by treating as external to the model the most important structural conditions which constrain care-seeking, by ignoring much of what happens during the management of chronic and critical illness, particularly in tertiary care settings, and by defining culture as the instrumental beliefs of individuals.

Anthropological studies of the past two decades have sought to overcome the limitations of these models. In the process, they have transformed the sociological conception of care-seeking into a tool for rich ethnographic investigations, and

sparked an important debate about the differential contributions of subjective culture (or belief) and objective or macrostructural contributions to care-seeking. Anthropological research in this field began with Romanucci-Ross's (1969) analysis of care-seeking as a "hierarchy of resort" to traditional, contact culture (Christian), or European curative practices on the Admiralty Islands. As studies of pluralistic health care systems developed in the 1970s, many focused on how "choice points" are organized in relation to diverse medical traditions and healers (Kunstadter 1976), how culture shapes the "health seeking process" and the ends sought through treatment (Chrisman 1977; Kleinman 1980; Nichter 1980), and how "therapy management" (Janzen 1978b, 1987) and referral are organized. Particularly elegant were studies of "natural decision making," based explicitly in the theory and methods of cognitive science, which developed formal models for "the nature of the information considered and . . . the nature of how it is processed" as members of a society confront illness and take action, rather than correlating characteristics of patients or diseases with types of care sought (J. Young 1978, 1981; Young and Garro 1982; cf. Garro 1986b). Critical studies within medical anthropology, however, pointed to limitations implicit in the care-seeking literature. Health decisions are far more constrained by objective social factors and macro-level structures of inequality, many have argued, than by subjective "beliefs" or cognitive factors.[20] For example, Janzen (1978a) called for placing such research in relation to macro-social structures, and Morsy (1978, 1980, 1990) has argued strongly that narrow attention to culture and perception ("socio-culturalism," she calls this) has led to the neglect of both local and global power relations which constrain many aspects of the care-seeking process. This debate has generated not only theoretical discussions but empirical studies designed explicitly to investigate the relative role of beliefs about the nature of an illness and such structural factors as availability and cost of treatment in determining choice of therapies (J. Young 1981; Young and Garro 1982; Sargent 1989).

These studies provide both an elaboration and a useful critique of much of the literature on care-seeking in sociology and social psychology. What I believe deserves thought, however, is why anthropologists so readily frame their ethnomedical research as an investigation of the choices individuals make in seeking care and how such analyses are framed. On close examination, even much of the anthropological literature shares with psychological and sociological studies an image of the rational, value-maximizing individual responding adaptively to disease, selecting among a stable set of choices and motivated by a set of meanings external to the subject.[21] This is an image which is consonant with the ecological view that gives analytic priority to those "sociocultural adaptive strategies that bring [ethnomedical systems] into being" (Foster and Anderson 1978: 33), as well as with the rationalist tradition of analyzing illness representations as folk beliefs. It is the convergence of the rationalist theories of medical beliefs, ecological theories of ethnomedical systems as essentially adaptive, and the analytic primacy of "choice" in studies of illness behavior that constitutes what I have called the "common-sense" or empiricist paradigm in medical

anthropology. The very common-sense quality of this paradigm hints at its role in reproducing conventional knowledge about the role of the individual in society (cf. A. Young 1980) and suggests several reasons why this perspective faces theoretical, practical, and empirical difficulties.

First, as I argued in chapter 1, analysis of illness representations as folk beliefs is grounded in Enlightenment theories of language and meaning, and shares the difficulties of such theories. Disease is often taken to be a natural object, more or less accurately represented in folk and scientific thought. Disease is thus an object separate from human consciousness, conceived, as Cassirer writes of positivist theorizing, as given "*tout fait*, in its existence as in its structure, and . . . for the human mind [*esprit*] it is only a matter of taking possession of that reality. That which exists and subsists 'outside' of us must be, as it were, 'transported' into consciousness, changed into something internal without, however, adding anything new in the process" (Cassirer 1944: 18, quoted in Sahlins 1976a: 62). Folk thought, from this perspective, is "inspired by definite ideas" of disease causation, as Rivers held, and is a way of making sense of the world akin to science (Horton 1967). But Rivers' proviso that "from our modern standpoint we are able to see that these ideas are wrong" always haunts such rationalist accounts, provoking a crisis of representation for anthropologists even as it provides a clear program for the health educators.

The analysis of folk beliefs as "information" or even "explanation" also suggests a political and psychological neutrality contradicted by the recent literature on illness representations.[22] Popular metaphors of warfare and machismo help structure explanations of AIDS and the immune system, but whether in science or health education, these figures also "serve as a powerful *patriarchal* instrument by re-inforcing assumptions about who gets sick or ill – the weak, the submissive and the un-manly" (Warwick, Aggleton, and Homans 1988: 220, summarizing Rodmell 1987; see also Clatts and Mutchler 1989). Respected epidemiological accounts of the origins of AIDS often disguise "accusation" as information, for example representing Haitians in racist and culturally stereotyping terms as a means of providing common-sense explanations of the appearance of the disease in Haiti (Farmer 1990a, 1992; Murray and Payne 1989). Political and psychological meanings projected onto disease are thus turned onto the sufferer. No wonder Sontag (1989: 94) calls for the metaphors of AIDS "to be exposed, criticized, belabored, used up."

Ironically, Sontag's desire to do away with metaphors, to "use them up," reproduces the Enlightenment ideal of a culture-free representation of disease, of disease as objective reality, the biosciences as providing neutral and realistic representations, and folk culture as rife with dangerous and ultimately mistaken metaphors.[23] Surely it is important to "expose" the stigmatizing aspects of both scientific and popular accounts of disease and participate in the work of refiguring disease, gender, and the human body. But for the anthropologist, replacing mistaken folk culture with the "value-free information of science" seems a deeply inadequate goal for either cultural analysis or committed action.

The development of alternative approaches for analyzing disease and its representation has thus emerged as central to medical anthropology.

A second central difficulty with ecological theories of medical systems and many studies of illness behavior is the analytic primacy given to individual choice and the implication that illness representations and ethnomedical systems are ultimately derived from the rational, instrumental activities of individuals. Such theories are forms of utilitarianism and, as I suggested in my discussion of the health belief model, are subject to Sahlins' critique of the analysis of culture as "practical reason" (Sahlins 1976a).

Sahlins traces a conflict present in anthropology since the nineteenth century between utilitarianism and what he considers to be a truly anthropological account of culture and social action, a conflict he argues revolves around "whether the cultural order is to be conceived as the codification of man's actual purposeful and pragmatic action; or whether, conversely, human action in the world is to be understood as mediated by the cultural design, which gives order at once to practical experience, customary practice, and the relationship between the two" (p. 55). Utilitarianism, he argues, is characterized by a logic which he finds exemplified in Lewis Henry Morgan's analysis of culture: "The general line of force of the argument, *the orientation of logical effect*, is from natural constraint to behavioral practice, and from behavioral practice to cultural institution: circumstance → practice → organization and codification (institution)" (pp. 60–61).

And so it is with utilitarian theories in medical anthropology. Diseases provoke individual and social responses, and these are codified as ethnomedical systems. In the ecological paradigm, a variant of "naturalistic or ecological" utilitarianism, culture is conceived as "the human mode of adaptation," and "explanation consists of determining the material or biological virtues of given cultural traits" (Sahlins 1976a: 101). Culture is thus absorbed into nature, and cultural analysis consists of demonstrating its adaptive efficacy.[24] Rational choice paradigms are variants of "subjective utilitarianism," a complementary perspective, and are "concerned with the purposeful activity of individuals in pursuit of their own interests and their own satisfactions" (p. 102). Though culture provides a "relativized set of preferences," ultimately "only the actors (and their interest taken a priori as *theirs*) are real; culture is the epiphenomenon of their intentions" (p. 102).

The critique of subjective utilitarianism is more appropriate to many studies of illness behavior in health psychology and medical sociology than to most anthropological studies of care-seeking, and by no means equally relevant to all strands of the diverse anthropological literature. Indeed, as I have said, many anthropologists who have written on care-seeking would explicitly reject the relevance of Sahlins' characterization of utilitarianism to their own work, and some have developed positions around a critique of standard empiricist accounts. This is certainly true of those who have focused exclusively on the relation of a sufferer's structural position in society to choice of care, rather than on individual experience and motives (Morsy 1978, 1980). It is also true of those in the cognitive tradition who have developed "descriptive" rather than "normative" decision models (Garro 1986b: 176–177). For example, James Young (1981: 10) argued that rather than developing decision models that produce "optimal choices – those having highest utility, lowest costs, or greatest benefits," ethnographic research should attempt to model options actually considered and "real-world decision processes," which thus best account for actual behavior.

My question remains why anthropologists have so readily assumed that the study of care-seeking choices provides an obvious entree into describing a medical system, and why individual decision makers, guided by their personal beliefs, are so often the primary focus of investigation and analysis. Although the anthropological literature on care-seeking is now quite diverse in methodology and theoretical orientation, utilitarian assumptions often appear in the common-sense reasoning in this literature. This is troubling. The analytic conjunction of the utilitarian actor, instrumental beliefs that organize the rational calculus of care-seeking, and ethnomedical systems as the sum of strategic actions is uncomfortably consonant with neo-classical economic theories of the utilitarian actor, the market place, and the economic system as precipitate of value-maximizing strategies. Little wonder common-sense theorizing is commonsense.

Sahlins concludes his critique of utilitarianism with an affirmation of an alternative vision of cultural forms.

> All these types of practical reason have . . . in common an impoverished conception of human symboling. For all of them, the cultural scheme is the *sign* of other "realities," hence in the end obeisant in its own arrangement to other laws and logics. None of them has been able to exploit fully the anthropological discovery that the creation of meaning is the distinguishing and constituting quality of men – the "human essence" of an older discourse – such that by processes of differential valuation and signification, relations among men, as well as between themselves and nature, are organized. (1976a: 102)

It is precisely the challenge of overcoming an impoverished conception of human symboling, of meaning made servant to the biosciences and to practical reason, that has given vitality to much of the theoretical discourse in medical anthropology during the past decade. And it is the elaboration of an alternative vision of cultural forms, of their intersubjective quality and their role in constituting our relationship to and knowledge of human biology, which I attempt to set out in these pages.

The empiricist tradition in medical anthropology has largely moved from common-sense theorizing to technically elaborated ecological and biocultural models. However, the greatest energy in the past decade has come from the development of positions critical of the empiricist approach and the emergence of a complex conversation among theoretical traditions. In the remaining pages of this chapter, I review three such positions, focusing again on the underlying theories of language and representation, thus setting the stage for the development of one such alternative for the field.

Illness representations as cognitive models: the view from cognitive anthropology

In the late 1950s and early 1960s, a small group of anthropologists, influenced by the emergence of the cognitive sciences in psychology, outlined a program for anthropology under the banner of "ethnoscience," "ethnosemantics," or "the new ethnology." The goal of investigating how language and culture structure perception and thus the apparent order in the natural and social world had its roots in Boasian anthropology, particularly in the writings of Sapir, Whorf, and Hallowell.[25] And the analytic language of investigating "folk models" was already present in cultural anthropology. However, linguistic anthropologists such as Goodenough (1956), Frake (1962), and Sturtevant (1964) set out to place cultural studies on a more scientific footing, one in which the structure of language and the structure of cognition jointly served as a basis for understanding culture and the structure of the cultural world as perceived by members of a society. Goodenough in particular called for the study of culture as shared knowledge, as the investigation of what people "must know in order to act as they do, make the things they make, and interpret their experience in the distinctive way they do" (Quinn and Holland 1987: 4). Goodenough's mandate focused on the identification of generative cultural models that account for what members of a society say and do. The effort to use replicable methods to "specify the cognitive organization of such ideational complexes and to link this organization to what is known about the way human beings think" (Quinn and Holland 1987: 4) has characterized over thirty years of studies in this field.

A modest thread running through cognitive studies in anthropology has been an interest in disease classification, ethnotheories of illness and healing, and the structure of illness narratives. In some cases, such studies have been conducted by medical anthropologists working in the cognitive tradition; in others, the medical domain has simply provided cognitivists an opportunity to investigate the nature of cultural models. Together with cognitive studies in medical psychology (Skelton, Croyle, and Eisler 1991), cognitive anthropologists have developed a distinctive theory of illness representations that contributes to current analytic discourse.

The earliest studies in the field were focused almost exclusively on categorization. Frake's classic study of the diagnosis of disease among the Subanun of Mindanao (1961) provided a model for eliciting and analyzing a disease taxonomy in terms of diagnostic categories and the symptoms that serve as distinctive features of each. The study was conducted without reference to biomedical categories; Frake sought a purely "emic" understanding of Subanun categories of skin disorders and of diagnosis as a "pivotal cognitive step" in attaching a name to an instance of "being sick" (1961: 132). Horacio Fabrega, a medical anthropologist and psychiatrist, elaborated Frake's techniques in the context of a larger investigation of the Zinacanteco ethnomedical system in Chiapas, Mexico. In a

series of studies, Fabrega and his colleagues used ethnosemantic techniques to identify native illness categories and the symptoms presumed to be the distinctive features of each, and to compare the knowledge structure and judgments of lay persons and healers (Fabrega 1970; Fabrega and Silver 1973). They then went on to compare Zinacanteco and biomedical categories (of skin disorders) as alternative systems of mapping symptoms onto disease names (Fabrega and Silver 1973: 135–140).

Undertaken in a context in which ethnomedical research had focused largely on describing exotic folk illnesses and providing generalized descriptions of health beliefs and practices, these early studies were a significant step toward the detailed investigation of everyday medical knowledge. However, in retrospect, their limitations are apparent. Their definitions of the domain of medical knowledge were extremely limited, and their analytic framework was narrowly referential, focusing almost exclusively on taxonomy. In large measure they thus reproduced the empiricist view of language as designating or pointing to objects in the world (cf. B. Good 1977; B. Good and M. Good 1981, 1982). Furthermore, they specified symptoms as the defining characteristics of diseases, although acknowledging that causation is often more closely linked to treatment than are symptoms. Thus, even when integrated into broader ethnographic studies, such as Fabrega and Silver's ethnography, the early ethnosemantic studies made claims about the scientific representation of folk knowledge that were overstated and unrealistic.[26]

A second generation of ethnosemantic studies of medical knowledge is represented by the work of Young and Garro (J. Young 1981; J. Young and Garro 1982). They investigated the structure of folk medical knowledge in a Mexican village, now however using a variety of relevant "criterial attributes" (including cause and severity) in addition to symptoms to model illness beliefs. This analysis was linked to a formal study of decision making. Four criteria – seriousness, type of illness, faith in the effectiveness of folk versus medical treatment for a given type of illness, and expense of treatment – were found relevant for distinguishing among illness categories in the choice of treatment from various folk or biomedical sources. By investigating decision making in individual cases of illness, they were able to develop a model that accounted for over 90 percent of treatment choices. This research went considerably beyond earlier studies by investigating knowledge of particular events, rather than only generalized medical knowledge, and by demonstrating the relevance of both medical beliefs and structural constraints on treatment choices. However, it continued to focus on criterial models and decision trees, which were giving way to new interests in schema theory in cognitive psychology.

By the early 1980s, cognitive anthropologists began to turn from "feature models" to various "schema" or "prototype" models to represent cultural knowledge. Drawing specifically on research on medical beliefs, D'Andrade (1976) voiced his dissatisfaction with earlier approaches:

> the attributes of disease with which informants are most concerned and which they use in making inferences about diseases are not the defining or distinctive features, but the connotative attributes of "seriousness," "curability," and the like. For example, what people know about cancer is not what defines a cell as cancerous, but rather that having cancer is often fatal and painful.[27] (1976: 177–178)

Increasingly, anthropologists sought ways to represent the "ethnotheories" that organize cultural worlds rather than lexical items that demarcate objects in that world. For example, Geoffrey White (1982a) reviewed methodological advances from taxonomic to propositional and inferential models for the study of "cultural knowledge of 'mental disorder'," suggesting that cognitivists and symbolic anthropologists join in studying the implicit "theories" of disease and ethnopsychological theories of social behavior in common-sense thinking about illness, rather than limiting attention to classification (1982a: 86). Clement's essay in the same volume is particularly illustrative of the transition to new approaches. Having used ethnosemantic techniques for eliciting data on Samoan concepts of mental disorders, she argued for reconceptualizing analysis in terms of "folk knowledge": "*folk* knowledge is viewed as an aspect of the group. Folk representations, the means through which folk knowledge is expressed, are . . . products of the institutionalized patterns of information processing and knowledge distribution with the group" (Clement 1982: 194). She thus sought to reanalyze her data in terms of cultural representations produced and reproduced in rituals, healing activities, and processes of social change, rather than solely in terms of individual classificatory schemes.

In efforts to move beyond feature models to a broader understanding of folk knowledge, psychologists' theories of "scripts," "prototypes," or "schemas" proved useful (see Casson 1983, Quinn and Holland 1987, and D'Andrade 1922 for reviews). Essentially, it was argued that culture provides simplified representations of the world – of cultural objects, of action sequences, of propositional relations – which generate statements and judgments that individuals make, organize behavior and life plans, and thus serve as the building blocks of cultural knowledge. During the 1980s, researchers attempted to demonstrate that simplified models of a wide variety of cultural domains – from Trobriand litigation (Hutchins 1980) to Ifaluk emotions (Lutz 1988) to marriage in the United States (Quinn 1987) – could account for much of the natural discourse and behavior associated with these domains.

Cognitive studies in medical and psychological anthropology during the past decade have focused largely on describing the ethnotheories or cultural models for emotions, psychological functioning, and illness in various societies. In nearly all of this work, it is assumed that simplified cultural models can be deduced which make sense of the cultural data elicited in these domains. Studies of cultural models have been undertaken not only to investigate folk models or common-sense reasoning, but to analyze the knowledge generated by the medical sciences or professional psychology as well.[28] Lutz (1985), for example, explored the meaning of "depression" among the Ifaluk people of the South Pacific. However, her investigation begins with an analysis of how Western ethnopsychology frames our understanding of depression by distinguishing "thought disorders" from "affective disorders" in a fashion that makes little sense for the Ifaluk. Similarly, Geoffrey White (1982b) shows that rather than simply studying how emotional problems are "somatized" in Asian societies, Western processes of "psychologization" and the very distinction of somatic from psychological need to be investigated in relation to our own ethnotheories of the person.

In a more specifically medical set of studies, Linda Garro (1986a, 1988, 1990) has investigated models of illness held by members of an Ojibway Indian community in Manitoba. In a study of explanations of high blood pressure, she criticizes previous research that represents illness models as "static," research which "does not represent the knowledge that generates [informants'] statements and that allows individuals to assimilate new information and make inferences" (1988: 89). Second, she argues that little research in medical anthropology has been able to identify and explain intracultural consensus and variation. Using open-ended explanatory model interviews to generate statements about high blood pressure, then analyzing true-false responses by informants confronted with such statements, Garro was able to identify "four key concepts of the prototypical model for blood that rises," stated in propositional form. She demonstrates that this prototype can be used to generate the majority of statements about high blood pressure among Ojibway informants, and also to identify individuals who hold idiosyncratic models not consistent with the "shared" cultural model.[29]

Cognitive studies of illness representations thus serve as an increasingly powerful critique of many generalized accounts of health beliefs and assumptions that "cultural beliefs" are consensual. They have provided clear analyses of the ethnotheories and prototypical schema associated with various domains of medical knowledge, and sought to investigate the nature of cultural consensus and variation. They increasingly combine formal methods of elicitation with analyses of natural discourse, and studies of illness or care-seeking narratives (Garro 1992; Price 1987) have again brought cognitive anthropologists into conversation with symbolic anthropologists. In some cases, implications of studies of cognitive models and "everyday reasoning" have been applied to problems of health education (Patel, Eisemon, and Arocha 1988).

Nonetheless, cognitive studies of "illness beliefs" or "cultural knowledge" – the terms are often used interchangeably – continue to share some of the criticisms of studies of folk beliefs outlined in the previous section. Although the analytic category "knowledge" has become more prominent and "belief" less, "knowledge" continues to refer largely to "what an individual needs to know" to be a competent member of a society. The epistemological issues at stake in claims to study folk "knowledge" have been largely ignored, and the individual mind (or brain) is seen as the primary locus of culture and meaning. Illness representations are thus largely understood in mentalistic terms, abstracted from "embodied knowledge," affect, and social and historical forces that shape illness meanings. Illness models are studied in formal, semantic terms, with little attention to their

pragmatic and performative dimensions or to the civilizational traditions that provide their intellectual context. Indeed, it is troubling to note that despite similarity in forms of cultural analysis between cognitivists and studies of medical semiotics in pluralistic medical systems (for example Staiano 1986; Ohnuki-Tierney 1981, 1984), cognitive studies have drawn very little on the larger tradition of civilizational analysis. As a result, studies of particular cultural domains often tell us remarkably little about the societies being studied.[30] Furthermore, as Keesing, a critic from within the tradition, notes, early cognitive anthropology was "naively reductionistic in its tacit premise that cultural rules generate behavior" and that "cultural rules generate social systems as well as behavior." He concludes, "Cognitive anthropology remains, I think, curiously innocent of social theory" (Keesing 1987: 387). This innocence of social theory, combined with the theoretical centrality of the individual thinker and actor in the cognitive tradition, opens the tradition to critical analysis of the sort outlined for empiricist theories.

Illness representations as culturally constituted realities: the "meaning-centered" tradition

Arthur Kleinman's work, beginning in the late 1970s, marked the emergence of a new approach to medical anthropology as a systematic and theoretically grounded field of inquiry within the larger discipline. At a time when ethnomedical systems were increasingly defined in ecological and adaptive terms, Kleinman designated the medical system a "cultural system" and thus a distinctive field of anthropological inquiry. His work combined an interest in complex medical systems, following in the Leslie tradition, detailed ethnographic analyses of illness and healing in Chinese cultures, theoretical development linked to symbolic, interpretive, and social constructivist writing, and an interest in applied medical anthropology. Kleinman's writing, editing, and advocacy for anthropological studies in medicine and psychiatry sparked – and paralleled – a burst of theoretical developments in the field; together these stimulated the emergence of both interpretive approaches and critiques of those approaches during the 1980s. Because the following chapters of this book are devoted to elaborating an interpretive approach to the field, conversant with critical analyses, here I will simply sketch out central themes of the interpretive tradition and its relation to the analysis of illness representations.

Whereas many writers in the empiricist tradition have treated disease as a part of nature, external to culture, and cognitive anthropologists have generally been indifferent to the epistemological status of disease, interpretive anthropologists have placed the relation of culture and illness at the center of analytic interest. Kleinman's work on explanatory models has often been misread. Eliciting and providing accounts of explanatory models of illness are certainly a means of analyzing patients' understandings of their condition, and serve as an entree to teaching clinicians to elicit the "native's point of view" during their clinical work

(Kleinman, Eisenberg, and Good 1978). Explanatory models are also cultural models which serve cognitive functions akin to those analyzed by cognitive anthropologists (Kleinman 1974).[31] But the more fundamental claim from the meaning-centered tradition has been that *disease is not an entity but an explanatory model*. Disease belongs to culture, in particular to the specialized culture of medicine. And culture is not only a means of representing disease, but is essential to its very constitution as a human reality (Kleinman 1973b; B. Good and M. Good 1981). Complex human phenomena are framed as "disease," and by this means become the objects of medical practices (see chapter 3). Disease thus has its ontological grounding in the order of meaning and human understanding (A. Young 1976). Indeed it is the mistaken belief that our categories belong to nature, that disease as we know it is natural and therefore above or beyond (or deeper than) culture, that represents a "category fallacy" (Kleinman 1977). This paradoxical claim has served as source for much of the theorizing and empirical research in the interpretive tradition.

First, it has served as the basis for exploring the relation of biology and culture and for studies of the cultural shaping of the phenomenology and course of illness. In epistemological terms, the claim that disease is an explanatory model was not an idealist counter to biological reductionism, but a constructivist argument that sickness is constituted and only knowable through interpretive activities. Rather than either reifying or denying the significance of biology, the interpretive paradigm has taken a strongly interactionist and perspectivist position. Biology, social practices and meaning interact in the organization of illness as social object and lived experience. Multiple interpretive frames and discourses are brought to bear on any illness event, and in Bakhtin's words, each offers "a concrete heterological opinion on the world."[32] Interpretations of the nature of an illness always bear the history of the discourse that shapes its interpretation, and are always contested in settings of local power relations (Kuipers 1989; Mishler 1986a; Kleinman 1986; B. Good and Kleinman 1985; B. Good, M. Good, and Moradi 1985). Empirical research has thus been directed both at how various forms of therapeutic practice construct the objects of medical knowledge – as "clinical realities" – as well as at how cultural interpretations interact with biology or psychophysiology and social relations to produce distinctive forms of illness. Studies of biomedicine have indicated surprising diversity in the construction of clinical realities across subspecialties within a given society (Hahn and Gaines 1985), and even greater diversity across national boundaries (for example Lock 1980; Maretzki 1989; M. Good, Hunt, Munakata, and Kobayashi 1993).

Culture, Kleinman argued early on (1973b), provides a symbolic bridge between intersubjective meanings and the human body. What is the nature and actual extent of culture's efficacy? In empirical terms, how variant are the symptoms and course of diseases? Research in this tradition suggests that cultural "idioms of distress" (Nichter 1981) organize illness experience and behavior quite differently across societies, that culture may provide "final common ethno-behavioral pathways" (Carr and Vitaliano 1985) and even construct unique

disorders. In particular, profound individual and cross-cultural differences in the course and prognosis of major chronic diseases have been shown to be produced by cultural meanings, social response, and the social relations in which they are embedded (for example Waxler 1977a; Jenkins 1991). The role of therapeutic practices both in the "clinical construction of reality" and in producing healing efficacy has also been investigated. In particular, rhetorical practices associated with healing activities have been shown to have powerful effects in a number of empirical studies (Csordas 1983, 1988; Csordas and Kleinman 1990; Finkler 1983; Gaines 1979, 1982; Kapferer 1983; Kleinman and Sung 1979; Laderman 1987, 1991; Roseman 1988). Thus, rather than focusing on representation *per se*, this tradition has investigated how meaning and interpretive practices interact with social, psychological, and physiological processes to produce distinctive forms of illness and illness trajectories.

Second, during the past two decades, medical anthropologists interested in meaning and interpretation have engaged in wide-ranging investigations of symbolic structures and processes associated with illness in popular culture and various therapeutic traditions. Rather than focusing narrowly on health beliefs or on distinctive features and cognitive models, such studies have provided interpretive accounts from many theoretical points of view – cultural studies of classical non-Western medical systems (Lock 1980; Ohnuki-Tierney 1984; Nichter 1989), semiotic and historical studies (Zimmerman 1987; Devisch 1990; Bibeau 1981), interpretive ethnographies of North American and European biomedicine (M. Good et al. 1990; Hahn and Gaines 1985; Lock and Gordon 1988), and studies of metaphor (Kirmayer 1988) and semantic networks (B. Good 1977). In contrast with the cognitive tradition, these studies have often been civilizational in scope and self-consciously theoretical, whether in relation to semiotics, hermeneutics, phenomenology, narrative analysis, or critical interpretive studies.

The analyses of "semantic networks" in Iranian and American medical culture, which I undertook along with Mary-Jo Good (B. Good 1977; M. Good 1980; B. Good and M. Good 1980, 1981, 1992; B. Good, M. Good, and Moradi 1985), should be read in this context. We developed the approach as an effort to interpret complaints of "heart distress" in a small town in Iran, as well as to understand how Greek medicine, which originated in a civilization and era far removed from twentieth-century Iran, seemed so tightly knit to the everyday lifeworld of the community in which we worked (cf. B. Good and M. Good 1992). We went on to use the approach for investigating the meaning of symptoms in American medical clinics and for exploring a number of the core symbolic domains of American medicine.[33]

Semantic network analysis provided a means of systematically recording the domains of meaning associated with core symbols and symptoms in a medical lexicon, domains which reflect and provoke forms of experience and social relations, and which constitute illness as a "syndrome of meaning and experience." Although the term semantic network has not had a uniform meaning or method, ethnographic research designed to map out the symbolic pathways associated with key medical terms, illness categories, symptoms, and medical

practices has been an important aspect of empirical studies in the meaning-centered tradition.[34] This research suggests that networks of associative meanings link illness to fundamental cultural values of a civilization, that such networks have longevity and resilience, and that new diseases (such as AIDS) or medical categories acquire meaning in relation to existing semantic networks that are often out of explicit conscious view of members of the society (for example Farmer 1992: 59ff.; Murray and Payne 1989). This research also suggests that semantic networks are not simple precipitates of social practices or explanatory models, though they are routinely reproduced through such practices. But semantic networks are deep cultural associations (such as that between obesity and "self control") that appear to members of a society simply as part of nature or an invariant of the social world and may therefore be part of hegemonic structures (cf. B. Good and M. Good 1981). Explanatory models in diverse fields such as behavioral medicine or obstetrics or immunology are often generated to rationalize or explain associations which are observed to be part of the natural order.

Third, in the past several years, interpretive studies have focused increasingly on embodied experience as the grounds and problematic of illness representations. Sickness is present in the human body, and sufferers often face difficulties similar to the ethnographer in representing its experience. Anthropologists in the interpretive tradition have had a special concern to produce "experience-near" accounts which render the body present, while criticizing purely cognitive renderings of illness. Some have used phenomenology explicitly to study the medium and structure of experience, conceiving the body as subject of knowledge and experience and meaning as prior to representation. History and social relations leave their "traces" in the body, and as Pandolfi (1990: 255) writes, "this body becomes a phenomenological memoir that opens a new way of interpreting distress and suffering and illness." Studies of "embodiment" (Csordas 1990; Gordon 1990; Pandolfi 1990) and the "phenomenology" of illness experience (Corin 1990; Frank 1986; Ots 1990; Wikan 1991; see also case studies in Kleinman and Good 1985 and M. Good et al. 1992) have thus become increasingly important ways of investigating the relation of meaning and experience as intersubjective phenomena. The difficulties of adequately representing suffering and experience in our ethnographic accounts, the problematic relation of experience to cultural forms such as narratives, and efforts to understand the grounding of such experience in local moral worlds are problems of current concern in this tradition (e.g. Kleinman and Kleinman 1991; B. Good 1992a; Das 1993; Mattingly 1989).

Interpretive studies in medical anthropology have been criticized from several sides – as unduly theoretical and irrelevant to most applied work, as attending too little to human biology, as lacking in the scientific rigor of epidemiology or cognitive studies, or as too "clinical" and too closely aligned with the interests of medicine. More importantly, some have charged that those who have analyzed how illness realities are constituted through interpretive and representational

processes have too often treated such realities as consensual and failed to provide a "critical" stance vis-à-vis illness representations and medical knowledge. Rhodes (1990: 164), for example, argues that "critical perspectives tend to emerge out of the cultural analysis of biomedicine" but that interpretive anthropologists have often failed to pursue such perspectives.

What I have described here as the interpretive paradigm was initially grounded in the studies of Asian medical systems and theoretically in symbolic or cultural analysis in American anthropology. Given the emergence of practice theories and wide-ranging forms of critical analysis, it is little surprise that some formulations in this tradition now seem dated or that the very term "meaning-centered" now seems best placed in quotes. However, the interpretive paradigm continues to maintain a distinctive perspective on language and representation, drawing on the historicist tradition and contemporary theorists such as Charles Taylor, Hilary Putnam, and Paul Ricoeur. Although this tradition stands in tension with Marxist or critical theories of culture and representation, I will be arguing that this tension is the source of much of the creative work in our field today.

The elaboration of a program of critical studies in medical anthropology represents a fourth orienting approach in the field, one which has developed in an on-going conversation with interpretive approaches, and it is to that approach which I now turn.

Illness representations as mystification: views from "critical" medical anthropology

A self-consciously "critical" approach to medical anthropology has developed in the past decade, both in conversation with and reaction to interpretive approaches to the field.[35] In part, this tradition reflects a growing interest in anthropology at large in more fully integrating history and historical analyses of colonialism, political economy, and "subaltern studies" of various forms into ethnographic analysis and writing. Again, I can only highlight several themes in this literature.

First, medical anthropology has begun to develop an important set of studies of how political and economic forces of both global and societal scope are present in the local health conditions and medical institutions studied by ethnographers. Such studies are an effort to understand "health issues in light of the larger political and economic forces that pattern interpersonal relationships, shape social behavior, generate social meanings, and condition collective experience," in Singer's (1990: 181) words. There is a long tradition in the medical social sciences and in "social medicine" of investigating the distribution of health services, the role of power in health care relationships and transactions (Waitzkin 1991), and the social institutions and inequities responsible for the distribution of morbidity and mortality – what Kleinman refers to as "the social production of disease" in contrast to the "cultural construction of illness," and what McKinlay (1986) calls the "manufacture of illness" (cf. Waitzkin and Waterman 1974). In recent years, medical anthropologists have drawn explicitly on dependency theory and other traditions of political economy theorizing to advance such research within anthropology (see Morgan 1987 and Morsy 1990 for reviews). Some have joined public health, ecological models, and political economic perspectives to investigate the "political ecology" of disease, in particular in the context of "Third World underdevelopment" (Morsy 1990: 27; cf. Turshen 1977, 1984, and Onoge 1975). Nearly all anthropologists today struggle to bring their understanding of historical and macrosocietal forces to bear on their ethnographic analyses of illness episodes and local worlds of health care (see Janzen 1978a, 1978b for early statements of this concern). And Marxist medical anthropologists have had a special interest in critical studies of medicine in capitalist and socialist societies.

Second, anthropologists in this tradition have attempted to develop a critical or neo-Marxist approach to the analysis of illness representations and medical knowledge. Often quoted is Keesing's critique of interpretive anthropology: "cultures do not simply constitute webs of significance, systems of meaning that orient humans to one another and their world. They constitute ideologies, disguising human political and economic realities. . . . Cultures are webs of mystification as well as significance" (Keesing 1987: 161). Theories of illness representations as mystification, in particular as mystifications of underlying social relations or relations of power, often draw on two sources: Gramsci's analysis of hegemony, and Foucault's "genealogy" of power. Gramsci's writing on hegemony focuses attention sharply on the role of cultural forms in rendering existing social relations common-sense, a part of ordinary reality, natural. For Gramsci, hegemony asserts itself subtly, leading to

> the permeation throughout civil society . . . of an entire system of values, attitudes, beliefs, morality, etc., that is in one way or another supportive of the established order and the class interests that dominate it. . . . to the extent that this prevailing consciousness is internalized by the broad masses, it becomes part of "common sense." . . . For hegemony to assert itself successfully in any society, therefore, it must operate in a dualistic manner: as a "general conception of life" for the masses and as a "scholastic programme."[36] (Greer, cited in Martin 1987: 23)

A critical medical anthropology forcefully poses the question of when illness representations are actually misrepresentations which serve the interests of those in power, be they colonial powers, elites within a society, dominant economic arrangements, the medical profession, or empowered men. Critical analysis investigates both the mystification of the social origins of disease wrought by technical terminology and metaphors diffused throughout medical language, as well as the "social conditions of knowledge production" (A. Young 1982: 277). Forms of suffering derived from class relations may be defined as illness, medicalized, "constructed as dehistoricized objects-in-themselves" (A. Young 1982: 275; cf. Taussig 1980, Frankenberg 1988a) and brought under the authority of the medical profession and the state. For example, symptoms of hunger or diseases that result from poverty, whether among the North American poor or the impoverished cane cutters of Brazil, are often medicalized, treated as a condition

of individual bodies – "diarrhea," "TB," "nerves," or "stress" – rather than as a collective social and political concern (Scheper-Hughes 1988). The transformation of political problems into medical concerns is often akin to "neutralizing" critical consciousness, and is thus in keeping with the interests of the hegemonic class (Taussig 1980; Scheper-Hughes and Lock 1987; Lock and Scheper-Hughes 1990). Analysis of illness representations, from this perspective, requires a critical unmasking of the dominant interests, an exposing of the mechanisms by which they are supported by authorized discourse: making clear what is misrepresented in illness.

Following from the analysis of illness representations as hegemonic, and counter to a resultant tendency to represent those who suffer oppression as passive, a body of scholarship has elaborated Foucault's assertion that "where there is power, there is resistance" (Foucault 1978: 95–96). Most influential has been Scott's analysis of the "everyday forms of resistance" among Malay peasants (Scott 1985) and his more recent study of the "arts of resistance" evident in the "hidden transcripts" of the oppressed (Scott 1990). For medical anthropologists, the term resistance has served to bring attention to cultural forms and activities which resist the increasing medicalization of our lives and thus of the encroachment of hegemonic cultural forms. A key text in this work was Emily Martin's (1987) study of the metaphors associated with reproduction in obstetrics and gynecology and in middle-class and working-class women's understandings of menstruation, birthing, and menopause. Martin attempted to show how the metaphors found throughout medical writing draw on images from commodity capitalism to represent women's reproduction and their status as reproducers. She investigated the hypothesis that working-class women have been more able to resist those metaphors than have middle-class women. A growing feminist literature has followed her lead and is now analyzing medical and scientific discourses about women and their bodies (for instance Jacobus, Keller, and Shuttleworth 1990).

The concept of resistance has also been used to analyze forms of illness experience more commonly studied as "possession," "hysteria," or "somatization." For example, Ong (1987, 1988) examines how violent episodes of spirit possession on the shop floors of multinational factories in Malaysia express peasant women's reactions to changes in their identity and to demeaning work conditions. Possession episodes not only serve as part of a complex negotiation of selfhood and reality, but resist the work of the factory by bringing production to a halt. Similarly, Lock (1990) has analyzed how the complaints of *nevra* of Greek women in Montreal "give voice to oppression," in particular in relation to their work in the garment industry, but at the same time "reinforce differences" and place these women in "a dangerous, liminal position" (cf. Dunk 1989; Van Schaik 1988). A "critical" analysis, in this tradition, is thus one that renders explicit the social and political meanings covertly articulated in the language and action of illness or possession.

At its best, the critical medical anthropology literature has served to advance

Allan Young's 1982 challenge to medical anthropology to develop "a position which gives primacy to the social relations which produce the forms and distribution of sickness in society." When combined with "thick description" and close analysis of meanings, such studies illuminate the many voices engaged in the struggle to respond to sickness and its threats and reveal how oppressive global and societal forces are present in small details of living and dying.[37] Not surprisingly, however, a great deal of the literature explicitly identified as "critical" is long on critique, long on program, and short on real historical and ethnographic analysis. Not surprising, I say, because the combining of macrosocietal and historical analysis with ethnographic writing is one of the most challenging problems of the discipline (Marcus and Fischer 1986: ch. 4). Not surprising also because rather dated Marxist analytic concepts – including the notion of cultural representation as "mystification" – are sometimes used in this literature with little critical awareness.[38] All too often explicit use of the term "critical" has served primarily to index and authorize the moral and political stance of the writer, rather than to further research and analysis. The juxtaposition of "critical" to "clinical" as positions in the field, and the implicit or explicit equation of "clinical" and "interpretive," is one example in which polemic has largely replaced analysis, in my opinion, and has been particularly misleading.

An important theme in the "critical" medical anthropology literature has been a set of pointed criticisms of those anthropologists who advocate introducing clinically relevant concepts from the social sciences into medical practice. Taussig sounded this theme early, warning that "there lurks the danger that the experts will avail themselves of the knowledge only to make the science of human management all the more powerful and coercive" (1980: 12), and the call to "disengage" from the "interests of conventional biomedicine" (Scheper-Hughes 1990: 192) has been sounded time and again (for example Singer 1989a, 1990; Baer 1986; Morgan 1990). Those who hope to encourage a more humane practice of medicine through their teaching and research activities within medical settings may be accused of liberal naiveté with some justification, given the current economics of medical practice in the United States and the enormous power of medicine to reproduce itself as a cultural institution. However, the criticisms leveled against those committed to making social science relevant to medicine deserve careful examination.

Criticisms of clinical applications of anthropology are often implicitly or explicitly based on an understanding of the clinical encounter as a "combat zone of disputes over power and over definitions" (Taussig 1980: 9). As Singer (1989a: 1198) writes, "we have accounts of the gathering of intelligence, the mobilizing of allies, the formulating of strategies, and the pressing of demands; in short, a narrative of struggle and combat in the very heart of physician-controlled territory." The likening of power relations in the clinical encounter to a "war" between doctor and patient seems to reflect Foucault's suggestion in "Truth and Power" (although the reference has not been made explicit), when he writes: "isn't power simply a form of warlike domination? Shouldn't one therefore conceive all

problems of power in terms of relations of war?" (Foucault 1980: 123). Surely there are occasions when physicians, some even knowingly, "wage war" on the poor, acting as agents of the state and corporate interests, duping the poor with scientific labels and placebo drugs which only serve to mystify, or even worse carrying out medical experimentation disguised by lies or silence. But equally sure am I that these occasions serve badly as the analytic prototype for understanding medical practice. Were this true, why should Navarro (for example 1989) or Himmelstein and Woolhandler (1986) be so concerned about the inequities in the distribution of medical services? And why should the sick, including we anthropologists (who usually have access to the best technical health services in the world), be so desperate for good quality medical care, even to be treated in a humane and caring fashion?

What is perhaps most surprising and worthy of research is not simply that the sick sometimes respond to physicians' power with individual or collective resistance, but that they respond in this fashion so seldom. Power differences among participants in medical or healing encounters are often enormous, certainly among the greatest that we routinely experience in contemporary American society. Yet these differences have seldom produced real resistance. Instead, access to power and the ability to employ it on behalf of the sufferer is universally required if one is to be considered a healer (Glick 1967).

Pappas (1990) distinguishes nicely between "power," "domination," and "exploitation" as present in medical institutions and relationships. However, when he – and many other "critical" medical anthropologists – analyzes "the doctor-patient interaction," these essential distinctions are often quickly lost, and all inequities of power and knowledge are reduced to "exploitation."[39] Medicine is not all war or exploitation, strident claims notwithstanding. It is also a conversation, a dance,[40] a search for significance, the application of simple techniques that save lives and alleviate pain, and a complex technological imagination of immortality. It is a commodity desperately desired and fought for, perhaps even a basic "human right," even as it is a fundamental form of human relating. All medical anthropologists should join the struggle for more equitable distribution of health resources and services and for more humane medical practice, even as we pursue critical analyses of medical institutions and the abuses of medical power. Attacks on clinically relevant writing in our field have done all too little to forward these goals.

Activists within the critical tradition have outlined a program of engaged activities, many of which anthropologists from all theoretical positions will support. Furthermore, the role for anthropologists in clinical teaching – as in community or public health activities – deserves continued debate. However, setting "clinical" over against "critical" is surely mischievous, confusing the point of application or the audience of a particular essay with a theoretical paradigm. Taussig 1980) might well be considered making "clinical" recommendations when he advocated using clinical transactions to unmask rather than mystify the structural sources of disease, and Waitzkin's (1991) recent analysis of clinical

discourse is an attempt to draw clinically relevant conclusions from a Marxist analysis. Anthropologists of all theoretical persuasions work in clinical, public health, and policy arenas, as well as carrying out basic research. The claim that "clinical" approaches stand in contradiction to "critical" perspectives thus detracts from efforts to confront the limitations of our research paradigms and ignores the contradictions involved in any practical engagement. It is a claim, I believe, which should be firmly rejected.

A more fundamental theoretical problem faces those who write of illness and its representation within the critical tradition, as commonly formulated. For anthropologists, interpreting the culture of another as "mystification" or "false consciousness" raises difficulties not unlike those associated with the rationalist analyses of culture as "superstition": it risks making actors to be dupes – of a hegemonic system, in this case – even as it authorizes the perspective of the observer over against the claims of those we study. When analyzed as mystification, knowledge claims of others are made subject to the analyst's epistemological judgments, with some version of a distinction between science and ideology replacing Evans-Pritchard's contrast of scientific and mystical notions. We (the scientists) know what lies beneath that which is hidden or mystified by naive ethnomedical theories, even if the peasants do not. Studies of "everyday forms of resistance" provide a richer frame for critical analysis, but the "romance of resistance," as Abu-Lughod (1990) points out, often disguises a similar delegitimation of the literal claims of women and men that they are suffering from physical pain or possessing spirits.

Richard Bernstein has criticized phenomenologists such as Alfred Schutz for their failure to comprehend the constitution of the lifeworld in social and historical terms. He argues that Schutz's commitment to analyze the commonsense world makes it impossible for him to understand "false consciousness" (whether conceived in Marxist or Freudian terms), because he is "ignoring or glossing over the complex mechanisms of resistance, defense, or self-deception by which individuals fail to find 'understandable' what may in fact be their genuine in-order-to motives" (1976: 164). However, he goes on to affirm the importance of a more radical phenomenology.

> If one of the characteristics of ideology or false consciousness is that it systematically *mis-takes* what is relative to a specific historical context for a permanent feature of the human condition, it might even be argued that a thoroughgoing phenomenological analysis is truly radical and critical. Indeed, phenomenology would enable us to see through the variety of ideological distortions that affect our understanding of social and political reality. (Bernstein 1976: 168)

Efforts to develop a critical phenomenology provide a meeting ground for critical and interpretive anthropologists, posing questions not yet adequately addressed. How might we develop theories that give actors "credit for resisting in a variety of creative ways the power of those who control so much of their lives, without either misattributing to them forms of consciousness or politics that are not part of

their experience . . . or devaluing their practices as prepolitical, primitive, or even misguided?" Abu-Lughod asks (1990: 47). How can we recognize the presence of the social and historical within human consciousness, recognize forms of self-deception and distortion, without devaluing local claims to knowledge? How can we write about illness in a manner that heightens our understanding of the realities of lived experience and still speaks to the larger social and historical processes of which the actors are only dimly aware? These are questions that face both critical and interpretive anthropologists as we move into the 1990s. They are questions which follow from critical theorizing of the past decade, but which require a rethinking of an epistemology that too easily transforms the meaning of illness and local forms of medical knowledge into mystification.

Emerging issues, recurring problems

> When cultures and tongues had interanimated each other, language became altogether different; its very quality altered: instead of a Ptolemaic linguistic world, unified, singular, and closed, there appeared a Galilean universe made of a multiplicity of tongues, mutually animating each other. (Bakhtin, quoted in Todorov 1984: 15)

Russian literary critic Mikhail Bakhtin's image of "a multiplicity of tongues, mutually animating each other," is an apt image for the medical anthropology of the past two decades. No longer do medical anthropologists speak with a single voice concerning "health beliefs and cultural logics." Even as multiplicity is increasingly present in the medical settings in which we work, so too are there now a plethora of voices in the field of medical anthropology. And so it should be. The theoretical positions I have outlined continue to develop in conversations "mutually animating" one another. Individual anthropologists cross theoretical perspectives, depending on the audience and issues they address, and new positions that transcend or reshape these are emerging. Lock and Scheper-Hughes (1990), for example, call for a "critical-interpretive approach." Arthur and Joan Kleinman (1991) explore the language of resistance to investigate the experience of chronic pain (cf. Littlewood 1992). Kaufman (1988) draws on phenomenology to interpret the experience of disability in a collection on Gramsci. And Mary-Jo Good investigates the "political economy of hope" in analyzing differences in oncological practice and investments in technology in North America and other societies (M. Good 1990; M. Good et al. 1992).

The image of "heteroglossia" over against a discourse which is "unified, singular, and closed" not only describes the current state of the field, but is an image of how we necessarily proceed. Disease and human suffering cannot be comprehended from a single perspective. Science and its objects, the demands of therapeutic practice, and personal and social threats of illness cannot be comprehended from a unified or singular perspective. A multiplicity of tongues are needed to engage the objects of our discipline and to fashion an anthropological – scientific, political, moral, aesthetic, or philosophical – response.

The accounts of the relation of language to illness vary sharply among the four

orienting perspectives I have reviewed here. In the empiricist approach, language is portrayed as depicting illness and as shaping the rational calculus of action. For cognitive anthropologists, language is viewed as the stuff of individual cognition, more or less widely shared, and as organizing individual perception. The interpretive tradition focuses on language as civilizational and intersubjective, as active and constituting, as opening to significance, while critical writers describe medical language as hiding, mystifying, and manipulating. Each of these perspectives represents a significant aspect of reality, and none has a corner on valid forms of cultural critique.

It is not my goal, however, to minimize what is at stake in debates among adherents of these perspectives, nor to suggest that these differences represent a dialectic to be resolved through some grand synthesis. The biomedical sciences and empiricist medical social sciences pose hard questions for advocates of any form of historicism or cultural relativism, and our inherited language is saturated with oppositions – between culture and biology, mind and matter, belief and knowledge – that subtly reproduce a history of opinion on these questions. Cognitivists pose difficult questions about the reliability of our data and thus of the conclusions of nearly all cultural accounts, in whatever tradition. And critical theories have rightly challenged hidden assumptions of much cultural analysis, enriching our analytic vocabulary immeasurably during the past decade. At the same time, each of these positions takes epistemological stances I have argued have troubling implications for medical anthropologists. Even current critical theorists maintain implicit distinctions between science and ideology that reproduce many of the difficulties of an older rationalist tradition.

I have argued that for medical anthropologists, these epistemological issues are not a matter of "mere" theoretical or philosophical interest, but a central concern for how we relate in writing and in action to those whose cultures and societies we study. How we conceive the authority of biomedical science is crucial to how we interact as anthropologists with those with whom we work. Thus, to fashion an epistemologically coherent position, one which makes sense of the claims of human biology and medicine and still acknowledges the validity of local knowledge in matters of sickness and suffering, is crucial for medical anthropology. Basic theoretical work is a central challenge to the discipline.

In this book, I attempt to articulate a position from within the interpretive tradition, conversant with critical theory, and to address a number of core issues that our discipline currently faces. The development of critical studies of how illness comes to meaning, of how reality (not simply beliefs about it) is organized and experienced in matters of sickness and care, is thus on the agenda. So too is the development of a "critical phenomenology": an approach which can provide a critical analysis of illness experience without the self-authorizing language of mystification or false consciousness remains to be written. Along with all of anthropology, we face the difficulty of joining political economy and interpretive perspectives, of integrating historical and global perspectives with rich cultural analysis in our ethnographic writing. And the development of a rigorous and

systematic program of comparative studies of sickness, one which provides a critical anthropological analysis of biomedical categories but addresses the genuine concern of Browner and her colleagues (1988) about the units for comparison, is especially significant.

I have suggested that much of the inherited language of belief and behavior, so readily assumed by the medical behavioral sciences, serves poorly for addressing these issues. I have also reviewed the limitations of current paradigms developed as critical responses to that language. The following chapters represent an attempt to probe the tensions among these positions, to clarify the deep paradoxes that frame all of our work, and to develop one path we might follow for the comparative study of illness and forms of medical knowledge. It is by no means comprehensive or exclusive. However, it suggests issues which must be addressed if the field is to move forward.

3

How medicine constructs its objects

In a discussion among several second year Harvard medical students in which I was participating, one young woman described how she felt her medical education was changing her.

> Medical school is really weird. It is a forced emotional experience. We handle cadavers, have feces lab where we examine our own feces, go to [a mental hospital where we get locked up] with screaming patients. These are total experiences, like an occult thing or boot camp.
>
> . . . it's *not* just an extension of college. College was also a total experience, but you could get by with less direct engagement, and still learn things. Here you have to *interact* with the information. When you dissect a brain you have to interact with these things and with your own feelings. Look at what you're playing with.
>
> I feel like I'm changing my brain every day, molding it in a specific way – a very specific way.

How medical students learn medicine, how they "change their brains every day," how they "interact with their information," offers insight into the highly specialized world of American clinical medicine. Analysis of this process will serve as entree to a set of claims about the relation of culture, illness, and medical knowledge which I want to develop in the remaining chapters of this book. I begin with a discussion of how medicine constructs the "objects" to which clinicians attend, arguing that *medicine formulates the human body and disease in a culturally distinctive fashion*, using students' descriptions of how they learn and how they change as a basis for insight into this process. The discussion of biomedicine in this chapter will provide a basis for exploring how medical anthropologists can compare disease and its formulation across cultures – in professional and folk practice, in popular interpretive schemes, and in the experience of those who fall ill.

The quotation is drawn from notes I took while participating in a conversation among a group of Harvard medical students. These and other data for this chapter come from interview transcripts and field notes, and are part of a study of Harvard Medical School which I have been conducting in collaboration with Mary-Jo Good and with the help of two of our students, Eric Jacobson and Karen