

Anne Sigfrid Grønseth

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to the study of health,
disease and illness; the strengths and
weaknesses of each, with special reference
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NAKMI

Oslo Universitetssykehus, HF, avd. Ullevål

Bygg 37

0407 Oslo

Tlf.: 23 01 60 60

Faks: 23 01 60 61

post@nakmi.no

www.nakmi.no

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Anne Sigfrid Grønseth

Introduction

In this lecture I start by establishing a thematic and conceptual context in which to understand health, illness and disease, as well as refugee populations. Then I turn to three approaches that highlight distinct and interrelated aspects in the exploration and understanding of illness and health. Each of these approaches will be evaluated in terms of its strengths and weaknesses with special reference to refugee populations. Introducing the different perspectives, I provide a general description supported by references to well known studies. Further, I have selected one recent case study for each, on which I elaborate more extensively. This responds to a wish to display an ethnographic closeness to the human issues discussed, and also to present studies within current medical anthropology. Moreover, the case studies are intended to illustrate relevant issues in the study of refugee populations. As there are decisive links between refugees and other marginal and less empowered groups, some of the studies referred to do not involve refugees per se, but raise crucial concerns that also apply to refugee populations.

Medical Anthropology

Medical anthropology is the study of health, disease, illness and healing across the range of human societies. It emphasizes human experience and how members of the community direct their behaviors, articulate ideas, and organize resources. It includes the ways in which human communities understand and respond to the challenges to their existence. It also includes peoples' access to health-restoring and health-maintaining resources, or the exclusion from these by the societies' power and economic structures. Moreover, it studies the meaning of the signs of illness and suffering as part of the overall study of cultural traditions.

The term 'medical' in medical anthropology refers not only to official medicine, but to any and all practices that are intended to address what lay folk and practitioners consider to be an affliction in need of attention. Medicine in this context includes the study of diseases such as tuberculosis and malaria. It also embraces health intervention efforts to reduce their occurrence, as well as a shaman's song about his mystical journey to bring back the soul of a sick

person, or the study of spiritual healers in, for instance, Mexico (Finkler 1985). Thus, medical anthropologists may refer to 'medicine' or 'medical traditions' to name the various curing and health-upholding practices found around the world. The medicine of hospitals and main-stream doctors of western industrialized countries is usually referred to as biomedicine. This name identifies the specific character of this medical tradition, based on science and with an emphasis on the physical body. Although biomedicine is globally distributed, it is seen as a specific medical tradition, distinct from other medical traditions such as Chinese medicine, Indian Hindu Ayurvedic medicine, Islamic Unani medicine, the medical traditions in Africa, or any other distinctive schools of healing and bodies of knowledge.

In addition to health, disease and illness, sickness and suffering are also related terms included in medical anthropological studies. Although these words are part of a common vocabulary, they have distinctive uses in anthropology. They express types of issues and inquiries that interest anthropologists. Following John Janzen (2002), anthropologists understand sickness as the individual or group experience of suffering, from the onset of a condition to its outcome. Sickness and suffering are subjective, and are of interest to anthropologists whether or not a medical expert finds a physical source for the experience. The dichotomy between illness and disease distinguishes the sufferer's perception of the experience from whatever objective physical entity or process is discovered. An individual can experience illness even though no corresponding disease or biological explanation is found. Likewise one can have a disease, such as cancer or HIV, without being aware of it, or feeling ill. This dichotomy between illness and disease has been criticized for accepting disease as an objective reality, while it is also part of a biomedical and cultural construction. Healing is used to describe the sufferer's own resolution of the experience of sickness and the medically defined treatment. In some cultural traditions the term for healing is derived from 'wholeness', and refers to the restoration of wholeness.

Disease and illness are associated with suffering pain, which in turn is part of one's body, self and personhood. Considering that body, self and personhood are constituted in a social process, pain and suffering are also social. Thus, when we study pain, suffering and illness, we study identity and society. Furthermore, when studying pain and illness, we also address questions about the experience of health, well-being and pleasure (see also Das 1990). The combined study of suffering and well-being cannot be perceived within an individual vacuum. Who is suffering and how they suffer are part of an intricate flow of power and resistance in social relations.

Every era tends to become associated with a particular illness that defines or influences it. In the Middle Ages, the bubonic plague was a social catastrophe. In later centuries, adults died from pneumonia, influenza, tuberculosis, typhoid fever, and dysentery. Today adults die from cancer, heart disease, and stroke. The infectious diseases of the postmodern era are replaced by chronic and gradually debilitating illnesses, such as arthritis, diabetes, and multiple sclerosis (Morris 1998). Explaining such changes is complex and difficult. According to the historian Thomas McKeown, the causes of sickness in every era are determined by "the prevailing conditions of life" (1988:91). Hans-George Gadamer takes a similar position when

he states that illness is always “a social state of affairs” (1996:20). Thus, illness involves not only hospitals and doctors but also social practices and meanings (see also Sontag 2002). As Davis Morris points out, what distinguishes postmodern illnesses is that they often involve a crucial component of ambiguity as to whether or not the disease really exists (1998).

An example is chronic fatigue syndrome (CFS). The clinical evidence for CFS remains inconclusive, and patients report varying symptoms that are hard to link to any organic cause. Many clinical doctors categorize the illness as psychosomatization. Another widespread postmodern illness is pain. Although most people regard pain as a symptom and not an illness in itself, many doctors now treat pain less as a symptom and more as a diagnosis. A common feature of many postmodern illnesses (for example CFS, pain, heart disease, AIDS and depression) is that they question the adequacy of the biomedical model and tend to bring forth concepts of healing (rather than cure), well-being, and wholeness (Morris 1998). In this framework of postmodern illnesses, refugees (such as Tamil refugees) often experience diffuse aches and pains that seem to add to these challenges (Grønseth 2006).

Refugee populations

According to the excellent volume by Robert Desjarlais, Leon Eisenberg, Byron Good and Arthur Kleinman on *World Mental Health* (1995), there are about 20 million “official” refugees in the world today. These are people that have fled to another country to seek refuge from war or starvation. The largest number of refugees are in Asia and Africa. In Asia there are close to seven million refugees, and close to five million in Africa. Less than 17% of the world’s refugee population relocates to the countries of Western Europe, the United States, Canada and Australia (Desjarlais et.al. 1995). Another 70 million people around the world have left their countries of origin primarily in search of work. Many are at risk of economic exploitation, poor living conditions, and prejudicial treatment.

In addition there are at least another 20 million people who are displaced within their own countries. Since these internally displaced people have not crossed the border of a nation-state, the United Nations plays no official role in providing them with humanitarian aid. National governments, however, do play a role, which means that the fate and welfare of these families and communities are strongly tied to regional politics. Quite often these people represent aboriginal groups, many of whom are forced to relocate due to environmental projects and receive little compensation for the displacement and turmoil they must undergo.

Migration alone does not lead to poor health. Rather a number of circumstances lead to distress and reduced health, such as employment status, housing conditions and traumatic events before, during or after displacement. There are three main factors that determine migrants’ well-being; whether one adapts well to the changes brought on by migration, whether one is living in a safe and healthy environment, and whether one can live a productive, meaningful and culturally integrated life (Desjarlais et al. 1995). Hence two groups are at great risk of distress: those who end up living in isolated and exploitative conditions, and those who seek refuge from starvation, violence and political turbulence.

In the following I will introduce three approaches to health, disease and illness, and address how each of these responds to sickness and well-being among refugees. First I present an ecological and biocultural approach, then a critical approach and lastly an interpretative approach.

The Ecological and Biocultural Approach

The ecological approach was introduced into medical anthropology in the late 1960s and early 1970s by Alexander Alland Jr. This approach holds that the human species is part of all environmental systems and interacts with other animal and plant species in energy-exchange cycles. Organisms adapt to various conditions and opportunities. This ability to adapt to changing circumstances is transmitted hereditarily, through genetic change, meaning that the basis of evolution is an important ingredient of the ecological or biocultural view of anthropology. Nutrition clearly becomes a logical focus for this view of medical anthropology, since the intake and outflow of energy is the central feature of the ecological perspective. This view also includes a distinctive view of disease. Disease becomes a concept that places the human community at an adaptive disadvantage. The fate of the human organism in the ecological approach has led to the inclusion of analysis of population profiles and patterned changes – that is, birthrates, death rates, fertility rates, life expectancies, epidemiologies of various diseases and overall population numbers – within given environments. The human privilege in ecological anthropology is the role of culture in human adaptation, in which medicine becomes a part of adaptive culture. Health is then not absence of disease, but related to or defined by adaptation. Along with the ecological perspective of disease came the interest in patterns of adaptation over the long term. In accordance with this, the focus turned toward the individual lifetime in a community setting, and made the entire life span a focus for study and healthcare attention. This in medical anthropology has come to be called the life course perspective, with interest in birth, transitions, traumas, growth, adulthood and death (Janzen 2002). These normal life events are too frequently presented as disease, while the life course perspective may show them, at times, as appropriate ritualization during periods of transition and trauma.

As Ann McElroy and Patricia Townsend (2004) point out, the ecological perspective is often accused of understanding individuals and cultures as if they always behave rationally (Good 1996:53), and the biocultural tends to “accept biological and biomedical data as an assemblage of incontestable natural facts” (Lindenbaum and Lock 1993:x). A critique of these approaches is voiced by the interpretative tradition – to which I will return later – that holds that disease is not a natural fact and therefore beyond culture. Biocultural theorists are not unaware that scientific knowledge is socially and culturally constructed, but they still privilege the findings of biomedical research. Even though such findings are contestable they are more than just the ethnomedicine of Western culture. Bioculturalists hold that biomedicine has cross-cultural and universal applicability when it accurately reflects biological reality.

Biocultural anthropology and reproductive ecology have made vital contributions to our understanding of human reproductive biology by highlighting the influence of ecological and

cultural factors on fertility and chronic disease. A marked biological variation exists among humans in hormonal profiles, reproductive function and symptomatology throughout the reproductive lifespan (Melby, Lock and Kaufert 2005, and others). A thorough study by Melissa Melby, Margaret Lock and Patricia Kaufert focuses on women's menstruation and menopause and shows that parity, workload and nutritional status may greatly affect ovarian function. Such variables may explain much of the cross-cultural variation as well as exposure to environmental chemicals like smoking, and consumption of soy isoflavones. Several studies show that a higher incidence of reproductive cancer in North American and Western European populations compared to Asian, African or Eastern European populations is associated with lower parity, resulting in higher cumulative lifetime exposure to gonadal steroids, particularly estrogens (2005:503). Melby, Lock and Kaufert show that this pattern spreads as developing countries adopt Western diet and habits with modification by use of oral contraceptives. Furthermore, even though first generation immigrants generally exhibit an incidence rate typical of their country of origin, second generation immigrants often assume the risk of their host country.

Another course of studies of biocultural medical anthropology is exemplified by a convincing study by Ronald Barrett on the stigma of leprosy in Varanasi, Northern India (2005). Let me start by quoting one of Barrett's informants:

The burden is worse than the bacteria. You see the infection is easily treated, easily cured with [multidrug therapy]... But even when the leprosy has been totally eliminated, many people will treat you as someone who is cursed for all time. That is the major problem. (Barrett 2005:216).

The statement was made by Ramchandra, a middle-aged Bansi man with Hansen's disease (HD) – or leprosy. The statement echoes a common assertion among Indian HD workers that the social stigma of leprosy is far worse than the disease itself. Contrary to a widespread belief, HD is a mildly contagious condition and can be readily treated with antibiotics in most cases. In spite of this clinical reality, Indians with HD are often permanently ascribed to the most untouchable categories of humanity (Frist 2000). The untouchability often persists long after they have been "cured" of the disease and leads to lifelong divorce, expulsion, loss of employment and exclusion from family and social networks (Koparty, Karup and Sivaram 1995). The extreme discrepancies between the clinical and social realities of HD in India highlight a common distinction in medical anthropology: the pathology of disease and the human experience of illness as suffering. Thus, it seems reasonable to segregate the bacteria of HD from the social burden of leprosy. Still, as Barrett eloquently argues, the physical and social stigmata of HD are too interconnected to be disentangled, and it needs to be approached as an illness of discrimination that *includes* its physical condition. Barrett (2005) concludes that processes of social stigma that lead to undertreatment, self-neglect and self-mortification, each and together exacerbate the physical stigma, which returns to reinforce individual and collective models of discrimination.

As shown in the cases presented, biology is an important factor in medical anthropology studies, which needs to be addressed. When considering studies of refugee populations, the biocultural approach may make a crucial contribution in terms of recognizing the need to monitor population profiles and patterned changes in the epidemiology of disease, birth and death rates, nutrition and diet, or life expectancy. Such studies are vital in securing a minimum of healthcare interventions and resources. At the same time, one should be particularly aware of how easily such profiles can be used to increase the social stigma and exclusion of refugee populations, as well as other minority and socially marginalized groups. Furthermore, the case of leprosy in India demonstrates that an understanding of the biological disease is not sufficient when it comes to combating its prevalence. A vast number of studies demonstrate the crucial significance of analyzing the social structures and power relations in which disease and illness are embedded. In the following, I introduce the critical approach to health, illness and disease.

The Critical Medical Anthropology Approach

Political economy and critical theories bring the health consequences of global and local power relations into focus. Such a perspective seeks to include materialistic, historic and dialectical relations. It crosscuts the disciplinary boundaries of anthropology, history, political science, and economics (McElroy and Townsend 2004). Central to such approaches are concepts of social class and social relations. This tradition reflects a growing interest in anthropology as a whole in more fully integrating history and historical analysis of colonialism, political economy, and “subaltern studies” of various forms into ethnographic analysis and writing. In line with such a development in the discipline at large, medical anthropology studies how political and economic forces, globally and locally, are present in the local health conditions and medical institutions studied by ethnographers. Within the medical social sciences and in “social medicine” there is a long tradition of investigating the allocation of health services, the role of power in healthcare transactions, and the social institutions and inequalities related to the distribution of morbidity and mortality (Good 1996). This is what Arthur Kleinman refers to as “the social production of disease” in contrast to the “cultural construction of illness”, and what John McKinlay (1986) calls the “manufacture of illness” (cf. Waitzkin and Waterman 1974).

Critical medical anthropology forcefully poses the question of when illness representations are actually misrepresentations, which serve the interests of those in power – be they a colonial power, elites within society, dominant economic arrangements, the medical profession, or empowered men. Forms of suffering derived from class relations may be defined as illness, medicalized and brought under the authority of the medical profession and the state. For example, the symptoms of hunger or diseases of poverty, whether among the North American poor or the impoverished cane cutters in Brazil, are often medicalized and treated as conditions of individual bodies – “diarrhea”, “tuberculosis”, “nerves”, “stress” – rather than as a collective social and political concern (Scheper-Hughes 1988). Nancy Scheper-Hughes

(1992) compellingly analyzed increased infant mortality in the hillside shanty town of Alto de Cruzeiro in Northeast Brazil. She found that mothers nurtured the infants that seemed likely to survive, but gave up on those who seemed frail, doomed to die as pitiable little “angels”. Scheper-Hughes leaves no doubt where the blame rests. Income was rapidly being transferred from the poorest families and regions to the wealthiest families and the industrialized south (Scheper-Hughes 1992).

A broad-reaching study by Min-Jung Ho (2004) examines the increased prevalence of tuberculosis. Not long ago, this number one killer of humans appeared to have been conquered in developed countries in the twentieth century by biomedicine and antibiotics. Then in the late 1970s the downward trend reversed. Tuberculosis affects mainly socially disadvantaged populations, such as the homeless, the impoverished, minorities and immigrants to the U.S. (Min-Jung Ho 2004). The persistence of tuberculosis among the socially disadvantaged, and its reappearance in developed countries, demand explanations that reach beyond the biological cause. In Ho’s study a need is seen to incorporate sociocultural factors. Ho selected immigrant tuberculosis because foreign-born persons contribute to over half of the tuberculosis cases in the U.S. While public health facilities emphasize biological factors in the control of immigrant tuberculosis, an ethnographic study among Chinese immigrants in New York City provides detailed cases that illustrate how cultural, environmental and politico-economic forces shape tuberculosis. I follow here with an illustrative case vignette:

Ms Zeng is a 45 year old lady from a village near Fuzhou in China. She knew that her tuberculosis was a bacterial infection and said that she was vulnerable to it because her constitution had been weakened by a variety of factors. First she was forced to undergo sterilization while living in China. Then she had to endure a difficult illegal migratory journey. She spent three months crammed together with over two hundred fellow passengers into the bottom deck of a cargo ship. They ate only a wheaten bun or a piece of dried tofu each day. When the ship docked in Guatemala, they were transported in an airtight banana cargo truck and then had to trek through the mountains. The migratory route was physically exhausting, over-crowded and with inadequate nutrition, all of which contributed to her weakened immunity and susceptibility to tuberculosis. Once she arrived in New York City, her voyage ended but not the challenges to her health. She worked over 13 hours per day in a poorly ventilated Chinatown garment factory, lived frugally, ate rice porridge or wheaten buns and rented a bed in an over-crowded Chinatown tenement building. She began treatment and was evicted by her landlord, making her sneak into the garment factory where she worked to sleep before she found a new place to sleep (Ho 2004:757).

In contrast to the biomedical suspicion that traditional Chinese medical beliefs and practices are an obstacle to biomedical treatment, practitioners and inhabitants of Chinatown describe their holistic approach as complementary to the biomedical treatment of tuberculosis. For instance, Ms. Zeng mentioned that her use of traditional Chinese medicine had been able to reduce the side effects of biomedical treatment. As a general feature, although not displayed

in the case of Ms. Zeng, the traditional Chinese emphasis on kin relations tends to have a positive effect on patient compliance, since family members support patients by allowing them freedom from social responsibilities while they recover. These are examples of how environmental and cultural factors affect the experience of Chinese immigrants with tuberculosis. Taking politico-economic factors into account, it appears that simply making antibiotics more readily available is inadequate. Having examined the case of Ms. Zeng, it is not difficult to comprehend that global politico-economic inequality, housing and working conditions in Chinatown, as well as exploitation by human traffickers and illegal employers, all must be addressed in an effort to control immigrant tuberculosis. In her article, Ho eloquently brings attention to how immigrant tuberculosis occurs when latent infections acquired in the home country are reactivated, but also calls for a heightened awareness of tuberculosis transmission among marginal immigrants within host countries.

An important theme in critical medical anthropology has been the criticism of anthropologists who advocate introducing clinically relevant concepts from the social sciences into medical practice. Michael Taussig warned that “there lurks 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). Also Scheper-Hughes calls to “disengage” from the “interest of biomedicine” (1990:192).

Studies of critical medical anthropology demonstrate how it is necessary to attend to economic, social and power structures that are crucial in shaping and maintaining sickness and disease among marginal and less empowered social groups, such as refugees. However, an overemphasis on global and local forces which generate social structures that produce refugee illness, can run the risk of not recognizing biological human processes in need of immediate attention and cure. Furthermore, a focus on structural conditions can lead to unintentionally picturing refugees and powerless groups as passive victims who have little or no access to reflection, resistance and agency. Still, many critical studies have elaborated Foucault’s assertion that “where there is power, there is resistance” (Foucault 1978:95-96). This is excellently demonstrated in studies by James Scott using the phrase “everyday forms of resistance” evident in the “hidden transcripts” of the oppressed (Scott 1990). In the studies of Scheper-Hughes on infant mortality in Brazil and Min-Jung Ho’s research among Chinese refugees in New York, another, but also overlapping kind of agency surfaces in a sensitivity to and interest in the sufferers’ experience of their illness and the meanings attached to it. These aspects of disease and illness have attracted increasing attention within what is often referred to as interpretative medical anthropology.

The Interpretative Medical Anthropology Approach

Interpretive theory comprises various frameworks that emphasize the study of meaning rather than scientific explanations (McElroy and Townsend 2004). Giving precedence to interpretation and meaning, one can explore health, disease, and illness as metaphors, as well as how the body is used symbolically in various cultures. Many anthropologists in

the biocultural and empiricist tradition have treated disease as part of nature. Cognitive anthropologists have been focused on classifications and are generally indifferent to the epistemological status of disease. In contrast, interpretative anthropology has placed the relation of culture and illness at the center of analytical interest (Good 1996). Arthur Kleinman defined the medical system as a “cultural system”. This made it a distinctive field of anthropological research that stimulated a burst of theoretical developments in the field.

Central to the interpretative approach “has been that *disease is not an entity but an explanatory model*” (Good 1996:53, italics in original). Disease belongs to culture and in particular to the specialized culture of medicine. Thus, culture is not only a means of representing disease, but is essential to its very constitution as a human reality (Kleinman 1973, Good and Good 1981). It becomes clear that disease has its ontological grounding in the order of meaning and human understanding. As such, it is a mistake to believe that our categories belong to nature, that disease as we know it is natural and therefore beyond or deeper than culture. Such a view, states Kleinman, represents a “category fallacy” (1977). This claim has served as source for much of the research in the interpretative tradition.

Rather than focusing on representations in themselves, the interpretative tradition has investigated how meaning and interpretative practices interact with social, psychological, and physiological processes to produce distinctive forms of illness and illness courses. Research suggests that cultural “idioms of distress” (Nichter 1981) organize illness experience and behavior differently across societies. Thus, culture may provide “final common ethnobehavioral pathways” (Carr and Vitaliano 1985) and even construct unique disorders. Recognizing human variation in illness experience and behavior is vital for healthcare practitioners and organizers who deal with refugees.

The role of therapeutic practices both in the “clinical construction of reality”, and in producing healing has been investigated. Several studies have shown that rhetorical practices associated with healing have powerful effects (Csordas 1983, Finkler 1983, Kapferer 1983). Such findings indicate a crucial need for patients and healers to share a belief in that the healing practice addresses issues relevant to the patient’s illness experience. Many refugees, such as the Tamils, do not always feel that there is a shared “clinical reality” in the meeting between patient and healer. Accordingly, many refugees are sceptical of the physician’s or psychologist’s treatment (Grønseth 2006).

In the past decade or so, there has been an increased focus on embodied experience as the basis of illness representations. This is related to the fact that sickness is present in the human body, and sufferers often face difficulties in representing this experience. Some anthropologists have used phenomenology explicitly to study the medium and structure of experience. They conceive the body to be subject to knowledge and experience, and meaning to be prior to representations. History and social relations are understood to leave their traces or “wounds” (Finkler 1991) in the body. As Mariella Pandolfi states: “this body becomes a phenomenological memoir that opens a new way of interpreting distress and suffering and illness” (1990:255).

It is within this last tradition that my exploration of Tamil refugees’ illness and pain is positioned (Grønseth 2006). As argued in the thesis *Lost Selves and Lonely Persons*, the Tamils

have difficulty in verbally articulating their illness and turn to the local healthcare center with troubling fatigue, aches and pains. Feeling themselves treated as “organs and not as persons” by the physicians, and socially insecure and degraded, the Tamils do not find the opportunity to voice their worries and despair. Rather, they repeat their visits and keep pointing to parts of the body that ache. The Tamils are thus disposed to articulate their experience of social and personal uncertainty and humiliation through bodily “expressions of the moment” (Grønseth 2006).

Interpretative studies in medical anthropology have been criticized from several angles. They have been assessed as unduly theoretical and irrelevant to most applied work as they are seen to attend too little to human biology. Moreover, they are faulted for lacking the scientific rigor of epidemiological or cognitive studies, and for being too “clinical” and too closely aligned with the interests of medicine. An important critique is also that such analyses too often treat the realities constituted through interpretative and representational processes as consensual. As such, they can easily fail to provide a “critical” distance vis-à-vis illness representations and medical knowledge. Accordingly, the interpretative approach stands in tension with Marxist and critical theories of culture and representation. Nevertheless, I hold that many interpretative studies also include a social criticism. The criticism is here not based in macro- and structural analyses, but rather departs from persons’ experiences and meanings that are intersubjectively perceived and created as part of everyday life (see for instance Grønseth 2006).

A rich literature has developed in medical anthropology that examines how violence, conflict and terror can structure the experiences of everyday life for those who suffer and survive. Anthropologists have focused on the complex meanings of violence. They have studied the lived experiences of war, the creative ways that conflict survivors attempt to comprehend and contest violence and terror, and how they recreate their lives. The concept of embodiment has been particularly useful in illuminating the range of these lived experiences.

In a powerful and alarming study from Sierra Leone, Henry Dough (2006) illustrates how idioms of power and terror attempted to transform individual bodies into political ones. Dough reveals how this was done by using individuals in symbolic ways to express structural domination through torture, interrogation, dismemberment, rape, or scarification. During part of the Sierra Leone conflict the state – at that time a military-rebel alliance that gained power by coup d’état – maintained control for a time by expressing that “Civilians don’t have blood”, meaning that civilians are less than human, without rights, as compared to the junta soldiers.

Over half of Sierra Leone’s population became displaced at least once during the conflict, some many more times, scattered either internally within the country or across the border in Guinea or Liberia. Estimates of those killed usually range between 50,000 and 75,000, while thousands more lost limbs in violent amputations, as rebels hacked off body parts of innocent civilians in a campaign of terror. Thousands more children and youth were forcibly conscripted to the war’s front line and trained to be guides, carriers, bodyguards, or fighters;

some were forced to commit horrible atrocities against family or village, thus severing their ties to home. Let me cite a small story that Dough uses in his article (2006).

Amara in Sierra Leone said:

I was in Sebhehun, sponsoring some boys to mine diamonds, and doing just well enough to take care of my family. One morning as I was coming back from clearing my farm, I saw that rebels had entered the town. I turned and started to go back, but it was too late – they saw me, and put a knife at my chest. “Where’s your gun?” they asked. But I didn’t have a gun... they made us all stare at the sky, and started taking my children away. I begged them, telling them I had a farm and needed my children to help me... then the commander came. He was a Liberian; he slapped me hard, and then they carried away my kids. [Amara, Kolomba Camp] (Dough 2006:384).

Among the group of refugees that Dough studied there was an amazingly large number who seemed to be suffering from “heart problems”. Young and old people seemed to suffer from what had become locally understood as an epidemic, and the pharmacy in town could not keep sufficient Inderal (a Western-manufactured beta-blocker class drug) in stock before it would sell out again. Various heart complaints had come to be associated with the war, or with the violence and fear that people experienced. These conditions or sicknesses previously known in Mende, Sierra Leone, as “spoiled hearts”, “heart cramps” or “heart pain” had come to be grouped together under the more general Mendecized syndrome haypatansi. Commonly, haypatansi results from excessive anxiety and dwelling on losses suffered during the war.

Although the word haypatansi originated from Western clinical medicine, it has taken on a local, Mende meaning since the beginning of the Sierra Leone war. It has a very different meaning from the Western biomedical notion of hypertension, which states that the disease is a “silent killer”, one largely genetic, with no manifesting symptoms. Local claims of hypertensive knowledge are attributed by medical practitioners to “a lack of awareness”. The Mende understanding, in contrast, is one in which people can more actively participate in their diagnosis and treatment. People very much recognized and associated environmental causes and symptoms with the disease. How people interpreted those cues and symptoms became crucial in understanding how they came to terms with the illness and what they could do about it.

Such a study relates to how illness has interpretations that can be socially contested, manipulated and affirmed in ways that both reflect and give meaning to the way sick people experience and understand distress. Janis Jenkins (1996) notes how *nervios* and *el calor* were expressions of Salvadoran women refugees responding to the traumatic loss and displacement they had suffered. Similarly, southern Sudanese refugees could use bodily metaphors to understand and cope with their traumatic experience; illness histories and refugee histories were thus proximate (Coker 2004). Biomedical practitioners also shape the way people experience or express conflict-related illness. Many of these are often at odds with the

explanatory models of individuals (Hunt and Arar 2001). Anthropologists have critiqued dominant Western classification-diagnoses of trauma-related illnesses, especially in their claims to represent universal human responses to extremely traumatic situations.

For example, the meanings and diagnosis of post-traumatic stress disorder (PTSD) have been traced through historical constructions of trauma, especially the study of war-traumatized World War II soldiers and Vietnam veterans. Celia Petty and Patrick Bracken (1998) have noted that because PTSD was created through Western categories, the therapy it entails is shaped by Western ideas of cognitivism, in which trauma is located as an event inside a person's head, rather than a social phenomenon. As a social phenomenon, recovery might be bound up with the recovery of the wider community. Instead, children and adults are universally encouraged to talk about traumatic experiences, or draw, paint or use storytelling to provoke them to relive the trauma. Petty and Bracken suggest that this treatment is profoundly individualizing, indicating that some sort of transformation can be effected through a self-achieved insight into one's own mind. Anthropologists have criticized this approach, referring to the insight that violence is a "total social phenomenon" (Mauss 1973 [1934]), and one with ongoing structural properties.

Conclusion

There is no clear picture in relation to the effects of migration on health. Evidence suggests that following migration, migrants' mortality rates either stay the same, increase or decrease in relation to mortality rates in their home countries (McKay et al. 2003). Mortality rates among international immigrants can be influenced by their country of origin, their destination and the process of migration itself. A similar picture exists concerning mental health. Migration does not necessarily cause mental illness, but migrants may find the experience of migration stressful and will benefit from social support from both the already established migrant community and the host community (McKay et al. 2003). There are higher rates of perinatal mortality and accidents and disability in many migrant groups compared to the native population (Bollini and Siem 1995). Paola Bollini and Harold Siem argue that poor health outcomes for migrants and minority ethnic groups are linked to the lower entitlements for these groups in the receiving societies (1995). Furthermore, they suggest that these groups are exposed to poor working and living conditions and are given reduced access to healthcare for a number of political, administrative and cultural reasons: for instance barriers resulting from language problems, different concepts of health and disease, or racism.

Such findings are important contributions in the quest to understand and deal with refugee health. As has been demonstrated, different aspects of refugee health conditions are highlighted by the three approaches I have discussed. Still, assessing the recent case studies by Ronald Barrett, Min-Jung Ho and Henry Dough, it appears that the distinctions between the three perspectives within medical anthropology are not mutually exclusive, rather they often overlap. Even though each approach has its merits, I argue that in regard to refugee health and illness, there is a specific need for studies that include a critical and/or

interpretative approach. Such studies have come to develop and emphasize the terms “social suffering” (Kleinman et al 1997) and “structural violence” (Farmer 2004).

Arthur Kleinman, Veena Das and Margaret Lock (1997) introduce “social suffering” as resulting from what political, economic and institutional power does to people and, in turn, from how these forms of power themselves influence responses to social problems. A useful characteristic of the term “social suffering” is how it addresses conditions that are usually separate but here simultaneously involve health, welfare, legal, moral and religious issues. As such, social suffering destabilizes established categories and links usually health related conditions such as trauma, pain and other disorders to political, cultural and, I would add, existential matters.

Paul Farmer (2004) has recently re-introduced the term “structural violence”, previously used at least by Latin American liberation theologians and in 1969 by Johan Galtung. Structural violence is violence exerted systematically. It is exercised indirectly by everyone who belongs to a certain social order. Thus, the term is meant to provoke discomfort in a moral economy devised to praise or blame individual actors. In short, structural violence is intended to inform the study of the social machinery of oppression. Oppression is further seen as a result of conditions that reside in the unconsciousness. Therefore, structural violence addresses the roles played by the erasure of historical memory, and other forms of de-socialization that allow conditions of structures that are “sinful” and seemingly “nobody’s fault”.

Social suffering and structural violence are concepts that I propose - better than health, illness and disease - capture the specific conditions and collective experiences of refugee populations, as also other marginalized and less empowered groups.

To depict and analyze the social and structural aspects of refugee experiences, one is fruitfully served not only by narrow and well targeted academic analyses in the form of short articles. I argue that one also needs a broad ethnography in the form of longer monographs. This is related to seeing anthropology, based as it is in ethnography, as different from other social sciences. Anthropology’s ethnographic approach and links to the humanities open the door to historic narratives, philosophical arguments and symbolic interpretations, which qualitatively set anthropology apart from other methods and analyses used in the health sciences.

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