WARNING CONCERNING COPYRIGHT RESTRICTIONS

The copyright law of the United States (Title 17, United States Code) governs the making of photocopies or other reproduction of copyrighted material.

Under certain conditions specified in the law, libraries and archives are authorized to furnish a photocopy or other reproduction. One of these specified conditions is that the photocopy or reproduction is not to be used for any purpose other than private study, scholarship or research. If electronic transmission of reserve material is used for purposes in excess of what constitutes "fair use," that user may be liable for copyright infringement.

NOTICE: Further transmission of this work is considered multiple reproduction of a copyrighted work, and is prohibited.

If you understand and agree to honor the conditions stated above, you may proceed to view this Electronic Reserve Article.
Medical/Psychiatric Knowledge in France and the United States: Culture and Sickness in History and Biology*

Atwood D. Gaines

Introduction

This chapter initiates an examination of the ontological status of "biology" in French and American biomedicine in the context of an ethnological study. The study considers two aspects of these Western biomedical systems. French somatic disturbances are discussed and their classification within U.S. medicine is considered. These disorders would appear as psychiatric problems in the U.S. The Sickness History of these forms of dysphoric affect then is presented, drawn largely from theology and the history of Latin religion. Then, reversing things, I examine U.S. social classification and patiethood and show the absence in France of the U.S.'s peculiar social classificatory system. Identical research (e.g., epidemiological) and clinical practices are shown to be impossible in the two traditions because of divergent sickness histories and conceptions of biology. Biology here is construed as a key symbol uniting disparate meanings and embodying cultural ideals of science and progress in U.S. medicine. Overall, the paper analyzes two areas of U.S. and French medicine in a way which allows each to serve as a standard of evaluation for the other. The paper represents the beginnings of an ethnology of biomedicines as cultural systems and is intended as a contribution to the anthropologies of biomedicine and of science.

Sickness History

The analysis demonstrates that certain central conceptions are not shared between the two biomedicines. The distinctiveness of the systems, it

*The short original version of the present paper, then titled, "Culture and Medical Knowledge in France and America," was read at the American Anthropological Association Meeting in Washington, D.C., December 1985.
is argued, derives from their unique "Sickness Histories," sedimented historical experiences from which have been created conceptions of particular sickness entities and their culturally constructed social contexts (e.g., "races," "classes," genders, age groups, regional or religious groups). Culture histories may be seen as containing, among other things, sickness histories. These are seen here as serving as culturally particular models of and charters for past and present responses (individual and group) to culturally defined sickness events.

Sickness histories, I shall argue, constitute the conceptual categories within and through which "local knowledge" (Geertz 1983) is expressed. The expression of this aspect of local cultural knowledge is the stuff from which professional and popular medical knowledge, practice, and organization are constructed. Those elements of medical knowledge and medical systems constructed on sickness histories include personal/cultural cognitive understandings of sickness such as Semantic Illness Networks (Good 1977), Explanatory Models (Kleinman 1980), and "prototypes and chain complexes" (Young 1982). However, sickness histories are categories of cultural thought and hence may be said to structure and to provide the content of medical discourse (Good and Good 1982), to determine a culturally (including scientifically) appropriate array of "core clinical functions" of a local healthcare system (see Kleinman 1980), and to promote the development of local, including biomedical, systems' medical specialties and their sickness categories (i.e., nosologies). Sickness histories are those historical experiences out of which a culture's folk and professional ethnomedicines fashion their understandings of sickness and ascribe meaning to them such that people organize themselves in a culturally sensible way to address their experiences. The notion of sickness history allows us to understand why cultures have distinctive and particular etiological theories, medical organizations, sickness realities, and specific means for diagnosing and treating them.

**Perspectives on Medicine**

This paper represents a shift in interest from early social scientific interests in health and illness in modern society. That work included the sociological concern for the patient and the physician, primarily in terms of their social roles (e.g., Apple 1960; Koo 1954; Freidson 1961; Parsons 1951). Subsequently, medical training and socialization became focal of research interest (e.g., Becker et al. 1961; Merton, Reader and Kendall 1957). An interest in medicine as a profession developed still later (e.g., Freidson 1975). An anthropological path, first opened by Caudill, Devereux, and Henry (see Gaines and Hahn 1985) and sociologist Renée Fox (see Marettaki 1985), has been rethought with new emphases, perspectives, and tools.

**Medical/Psychiatric Knowledge in France and the United States**

Modern medical anthropological interest has focused on the actual knowledge and practice of biomedicine, rather than employing idealized images, whether positive (e.g., Foster and Anderson 1978; Hughes 1968) or negative (e.g., Baer, Singer and Johnson 1986; Frankenberg 1980; Navarro 1976). Some research endeavors were undertaken as theoretical enterprises while others were directed toward both understanding and improving medical and psychiatric care (e.g., Bosk 1979; Engel 1977; Hahn and Gaines 1985; Kleinman, Eisenberg and Good 1978; Mishler et al. 1981; Young 1980, 1981, 1982).

The key characteristic of most such studies is that they have developed and employed perspectives from modern interpretive social science, itself derived from the work of such scholars as Weber, Schutz, Mead, Dilthey, Husserl, Turner, and Geertz (Rabinow and Sullivan 1979, 1987). Interpretive studies sought to demarcate and focus on biomedical knowledge and practice as culturally constructed and as problematic. That is, medical knowledge was not seen as given in or reflecting an autonomous, independent "nature" (e.g., Gaines 1979, 1982a,b; Gaines and Hahn 1982; Gordon 1988; Kleinman, Eisenberg and Good 1978).

In the late 1970s an aspect of Western medicine, psychiatry, was first defined as a "cultural system" (Gaines 1979, after Geertz 1971, 1973) with the other specialties of medicine becoming so viewed shortly thereafter (Gaines and Hahn 1982; Hahn and Gaines 1985; Hahn and Kleinman 1983). This formulation has been recently restated (Rhodes 1990). A similar approach, derived from the sociology of knowledge and termed social constructionism, developed in British sociology (Wright and Treacher 1982a). The term cultural constructionism has been proposed more recently to distinguish the anthropological from the sociological enterprise and to label, develop, and distinguish interpretive social science in medicine from empiricist, functionalist, critical medical anthropologies (Gaines 1991, chapter 1, this volume).

Especially important has been the demonstration that medicine is both a part and an expression of a particular culture and society. This contrasts with the critical medical anthropological view wherein medicine is seen as constituting a distinct social stratum. This stratum is said to be ideologically distinct and autonomous from the wider society and is set apart and opposed to it. Medicine is said to function as a system of social control (Navarro 1976; Waitzkin 1979) and as establishing hegemony over one society or another (e.g., Frankenberg 1980, 1988). Medicine's function and its being are seen as a "reflection" or "product" of one or another asserted material entity, e.g., a capitalist world system, means, modes, and/or relations of production (Baer, Singer and Johnson 1986; Frankenberg 1988; Waitzkin 1979; also see Rabinow and Sullivan 1987). Such functionalist arguments typically are made by self-labeled "critical theorists" about medicine and other professions.
However, Marxist and critical analyses actually, "hide precisely the quality that endows medicine with such great potential ideological and cultural power. (They) hide its apparent distance and distinctiveness from other social practices" (Wright and Treacher 1982b:11). Critical approaches' use of notions of class and ideology make it quite impossible for us to differentiate medical from any other professional knowledge and any other professional practice such as law or politics. They also assume a homogeneity and universality that cannot be demonstrated ethnographically. These and other functionalist sociological approaches do not make central use of the key tool of modern social science and of the modern anthropological understanding of human events and experience: the concept of culture (Douglas 1979).

The central element in the new research perspective on modern medicine is that it is a cultural medicine, an "ethnomedicine," albeit a professional one. Further, biomedicine is a domain comprised of a system of sociocultural knowledge and practice focally concerned with cultural definitions and notions of self, existence, morality, mortality and morbidity, and of nature (Gaines 1982b, 1992; Hahn 1985; Gordon 1988; Young 1990).

In medicine we find the contrasting "medical model" of sickness. In this model, disorders are constructed in purely biological terms (Engel 1977; Mishler et al. 1981). Those disorders that do not currently fit into this model are assumed to be explicable in biological terms at some future time when biological knowledge, it is assumed, will have increased such that the pathological processes will have yielded to, and/or arisen into, the gaze of medicine and psychiatry (Foucault 1963).

In biomedicine, universal sickness entities are seen as expressed in cultural, empirical, pathophysiological processes and histopathological structures. The model, "assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological and behavioral dimensions of illness" (Engel 1977:130); nor does it allow for cultural dimensions (Kleinman 1986, 1988) including the sociocultural meaning of "norms" which, for this writer, encompasses the others. The professional ethnomedicine of Western culture may be properly characterized as "a preeminently, even exclusively, biological medicine" (Gaines and Hahn 1985).

Hence, an appropriate designation for this domain of Western cultures is biomedicine.

Analysis suggests that some rather central conceptions are not shared between French and United States biomedicines. The two biomedicines appear not to be simply units or divisions of a universal medical system focused on a universal natural biology and pathology. Distinct medical systems question the notion that one biomedicine is exercising hegemony over all other medical systems of the world (e.g., Singer 1986; Frankenberg 1988). Rather, these professional ethnomedicines appear as distinct symbolic systems which, like world religions, are locally received and constructed and, through local history, create and (re)interpret central symbols (e.g., biology). The distinctiveness of biomedical systems derives from their unique sickness histories which incorporate theological and social historical elements and from their particular medical/social histories (e.g., see Lesch on the emergence of experimental physiology and its method in France in the last century [1984]).

Culture history provides the semantic richness, the polysemous character of sickness experiences. Culture history contains sickness histories which serve as charters for subsequent personal and group responses to contemporary illness experiences. Below, I present data on sickness entities in France that are considered somatic disturbances. These would be classified, if they existed, as psychiatric problems in the United States. The sickness history of these forms of dyshoric affect is presented. It largely derives from theology and the history of Latin religion (see also Gaines 1991) from which this is drawn. The unique sickness history explains why these diseases/illnesses are not found in United States biomedicine or dominant popular culture. Such conditions are, however, widely found in industrial and non-industrial Mediterranean traditions and their daughter Latin traditions in the New World.

Then, reversing things, I examine "racial" classification and patienthood in United States psychiatry and there indicate the absence in France of that peculiar system of social classification. It is shown how identical research (e.g., epidemiological) and clinical practices are, therefore, impossible in the two traditions. Overall, the paper analyzes two areas of U.S. and French medicine in a way which allows each to serve as a standard of evaluation for the other in one domain. This arrangement allows us to view two areas of each medicine in a brief report and prevents the use of one form of biomedicine as an implicit, unexamined and idealized, standard of comparison as has been the case in much of medical anthropological writings (Gaines and Hahn 1985), e.g., Foster and Anderson (1978) and Hughes (1968; 1990). The paper concludes with some explanations for the maintenance of the cultural ideal of a purely scientific, biologically-based biomedicine in the face of much contrary evidence. Biology is there construed as a key symbol uniting disparate meanings and embodying cultural ideals of science and progress (Ortner 1974).

Sickness in France

Spasmophilia

The last twenty years or so have seen a growing popular cognizance in France of a disease entity called spasmophilia. Spasmophilia, first noted in
the French medical literature in the late 1950s, represents a new professional ethnomedical diagnostic entity. In the last decade or so, it has increased dramatically as a diagnosis, increasing some sevenfold in the decade between 1970 and 1980 (Payer 1990:38). Because both professional and lay persons recognize spasphomphile as a form of affliction, it is both an illness and a disease (Eisenberg 1977; Kleinman, Eisenberg and Good 1978). It is constructed as a medically and socially significant disorder; therefore, it is also a sickness in Young's (1982) sense. As we show that professional medicine's diseases are cultural constructs, the once useful distinction between disease and illness dissolves.

In the public media (in 1980 and 1983 in the author's experience) physicians and contemporary news reports suggested that as much as 35 percent of the adult French population may be affected annually. It is one of a number of diagnoses in France that are unknown in other Western countries (Gaines 1986a, b; Gaines and Farmer 1986; Helman 1990; Payer 1988). And we note that there are a number of diseases found in other Western countries that are unknown in France.

The condition of spasphomphile appears to be related to several other sickness entities found in France. These include fatigué, "tired, fatigued" (Dodier 1985) and triste (or fatigué) tout le temps ("sad [or tired] all the time"), both discussed below. Spasphomphile has been accepted by the general population as a valid and recognizable illness. Informants stated that one could easily recognize the condition, making self-diagnosis possible. The public use of the label indicates the cultural sense which the condition makes, though its prevalence and incidence are as yet poorly understood.

The disorder is marked by a number of nondiagnostic symptoms such as mild fatigue, bodily aches, mild nausea, listlessness, loss of appetite, sleep disturbances, and distractibility. No particular symptomatic picture is asserted to be common to all cases; no identifiable, stable syndrome is asserted to exist. Symptoms vary from case to case as does their severity. Although U.S. physician informants can translate the term and even locate it in medical dictionaries, the term here refers to various forms of hypersensitivity; they have no knowledge of or reference for the term as a specific disease with a known etiology.

The diagnosis of the disorder, seen as a physical, medical problem and not a psychiatric one, actually depends upon the social state of the person. The disorder appears to the U.S. psychiatric observer as an expression of dysphoric affect expressive of an existential problem, not a syndrome of bodily aches and pains. In fact, it is common for one to be labeled as having a susceptibility to the disorder (one then is a spasphomphile) in the absence of any symptoms at all. Stress, an idiomatic term recently applied to an historically ubiquitous French experience of life as wearing, difficult, and burdensome, and "mineral deficiencies" appear to be the most common etiological hypotheses (lay and professional) for the rather ill-defined malaise of spasphomphile. A physician may prescribe magnesium, acupuncture but also rest and the seeking of care, specifically and especially in a secure, i.e., at one's family home, even if at far remove (see Payer 1990). The latter suggestion derives from a culturally constituted notion of vulnerability seen as characteristic of those away from home. In another Mediterranean culture, a similar vulnerability of travelers or migrants is expressed as the susceptibility to the affliction of "fright illness" among Iranians (Good and Good 1982). The contrasting but overlapping etiological hypotheses and treatment regimens suggest that social information and demeanor, rather than specific, pathognomonic physical symptoms, are central to diagnosis.

In this regard it is perhaps noteworthy to point out the typical prominence of social features in the diagnoses of disorders in the Mediterranean culture area and its Latin New World daughter cultures. These conditions are exemplified by fright illness and "heart distress" among Iranians (see Good and Good 1982), the Italian evil eye (Foulk et al. 1977), Moroccan she-demon possession (Cranziano 1973) and, in Latin America, sueto (Rubel 1977), tristitia and pena (Tousignant 1984). (Schepers-Hughes [1988] incorrectly describes these latter forms as "wasting diseases" in her effort to categorize them as related to problems of hunger in Brazil.) (For a delineation of the Mediterranean culture area, see Davis 1977; Gaines 1978, 1982a; Gaines and Farmer 1986; Gilmore 1982; Peristiany 1966; Pitt-Rivers 1963, among others.) It is possible that the disorder is a new, modern label for an old idiom of distress, that of being fatigué, a condition described below.

Fatigué

Another disorder, labeled simply fatigué, used as an adjective and expressed as, "je suis fatigué" (I am tired [or fatigued]) or "je me sens fatigué" (I feel tired) is quite widespread in France. The expression refers to a state of being, an illness state, and may be contrasted with another experience of la fatigue, which expresses a sense of lassitude caused by work that is too difficult or too long (e.g., Malgré la fatigue, j'écris—Despite fatigue, I continue to write).

In an article on sickness and its moral justification in the French workplace (Dodier 1985), "being tired" was shown to be a common sickness, in fact, one of the most common experienced by both blue- and white-collar workers. Diagnosis, treatment and management of this condition by physicians in France is usual, expected, and appropriate. Leaves of absence for "rest" ranging from a matter of days to a month or more are regularly prescribed by physicians and are deemed appropriate (morally justified) by both employers and co-workers.
The condition is not a symptom of another or other disorders. Rather, in this context, it refers to a specific disorder. One notes, though, that it is also the means by which the French express all manner of other illness states in terms of degree, ranging from "un peu fatigué" to "bien fatigué" to "fatigué tout le temps" ("a little tired," "very tired," "tired all the time") (for example, see Wylie 1957). Colloquially, the terms mean "mildly ill," "very ill," and "seriously ill." Only the first two terms may or may not also refer to other diseases recognized by biomedicine. The etiology of fatigué as a disorder is not overwork or lack of a few nights’ sleep, both causes of la fatigue. Rather, the etiology of being fatigué is a perceived burdensome life situation. This condition may appear at any time and does not necessarily derive from a specific, unusually stressful period or noxious event in one’s life. All aspects or phases of life are seen in France as difficult, burdensome, and taxing. One’s day-to-day life is seen as a constant "struggle," which periodically simply weighs one down. In France, it is deemed appropriate to have a view of life as tragic or sad. To view life otherwise is an indication of immaturity and of a shallow personality (Gaines 1982a, b; Wylie 1957). This connection, of maturity and personal validity with the understanding of and appreciation for sadness and the tragic, is also integral to the cultural psychology of other areas of the Mediterranean including Iran (see Good 1977; Good, Good and Moradi 1985), Italy (Cornelsen 1971), Greece (Blue 1991; Campbell 1964; Lee 1959), and North Africa (Ahu-Lughod 1986).

In France, medical leaves for fatigué are viewed routinely by employers, colleagues, and physicians as appropriate when other signs are present (drawn appearance, irritability). The disorder is widely recognized and morally sanctioned in popular and professional circles. We note also that the notion of tiredness as a common, morally justified, medically recognized and treated disease was entirely unproblematic to the French author Dodier (1985). However, such would clearly be problematic to U.S. clinicians, researchers, and lay readers. In U.S. folk and professional ethnomedicine, tiredness is a symptom of a number of disorders; it does not constitute a disorder in and of itself. In Dodier’s work, he sought not to find a disease behind being tired, because being tired is the disease.

Triste/Fatigué Tout le Temps

A third disorder is known both in French professional and folk ethnomedicine; it is therefore both a disease and an illness as are spasmodhile and fatigué. This disorder is triste (or fatigué) tout le temps ("sad (or tired) all the time"). This disorder is a chronic version of fatigué with similar complaints and behavioral manifestations, but it differs in two very important ways. It has a specific precipitating event, generally a personal loss or great

disappointment, and it is chronic, which is to say of very long duration, ranging from years to a lifetime (Gaines and Farmer 1986; Gaines 1986a).

Informants queried in Paris and Strasbourg all knew of the disorder, could describe it and its various possible symptoms. Each could relate a tale of one or more people personally known to them who had the disorder, many of whom had seen physicians. This and other research indicates that individuals will seek medical help for the disorder’s symptoms and/or for exacerbations of the condition if not specifically for the disorder.

The symptoms of this French disorder are many and various and include chronic disturbances of vegetative signs, such as sleep and appetite, as well as problems of concentration and memory, sad affect, sometimes psychomotor retardation, chronic tiredness and weakness, distractibility, and other, but again nonspecific, multiple symptoms. “Sad (or tired) all the time” is a syndrome with a widely varying symptom picture. Its origins appear to lie in reactions to some form of perceived traumatic event, such as a miscarriage, the death of a child, spouse, or close friend, or the termination of an important relationship. Parisians and Strasbourgeois informants (in 1982 and 1983) also suggested that the precipitating event may not be a loss but a failure to achieve some important personal goal such as entrance to a favored school or winning an important sporting contest. Examples of both can be found in the literature and films of France (e.g., the film, La Femme à Côté, and the 1980s novels Élise ou la Vrai Vie and Les Enfants du Siècle).
All of these conditions (and others, such as the French Revolution, the famous medical and political upheaval) are widely known and discussed in the popular press and the United States. These conditions reflect a deeper cultural dynamic that is not always evident in the surface-level narratives of the time. The French Revolution, for example, is often portrayed as a sudden and radical event, but in reality, it was the culmination of a long-term social and economic crisis. Similarly, the medical conditions that are associated with the French Revolution, such as the cholera epidemic, were not a sudden event but rather a manifestation of the underlying social and economic issues of the time.

The French Revolution and the cholera epidemic are both examples of how historical events can be seen through a dual lens of history and science. The scientific understanding of these events is critical for understanding their impact and legacy, but it is also important to consider the social and cultural context in which they occurred. In this way, we can gain a more complete understanding of these events and their impact on society.

In conclusion, the history of medicine and science is deeply intertwined with the history of society. By examining the cultural and social context of historical events, we can gain a deeper understanding of the events themselves and the impact they had on society.

References:


Notes:


In short, such histories would be interpretive histories of medical knowledge, practice, and organization in their cultural contexts. Noting that other writers have begun to show the role of theology and philosophy in the shaping of the experience of dyshoric affect in the West (see Jackson 1985; Lutz 1985; Obeyserekere 1985), we may turn to a brief examination of aspects of religious history in the West that bear on the French disorders.

Religion and Medical History in France

Historical material suggests that the three disorders are related and, indeed, likely share a common origin. An examination of the psychiatric history of the notions of acedia, tristitia, and melancholia, forms of what Jackson (1985) calls "dejected states," provide an understanding of spasmodhils, fatigued and triste/fatigue tout le temps.

Jackson finds three forms of dejected states, acedia, melancholia, and tristitia, all of which "belong to the history of religion, in particular to the religious scheme of the cardinal sins in Christianity" (1985:44). The condition of acedia, a sin, developed out of the examination of the particular experiences of members of the desert anchorite community near Alexandria in the fourth century (A.D.). The isolation and inactivity produced mental states which detracted from contemplation. The unusual mental states of acedia soon acquired behavioral references. Shifts in emphasis from one pole (mental state) to the other (behavioral modes) have occurred through the centuries. On the one hand, acedia was described as "carelessness," "weariness," "exhaustion," "negligence," (in contemplative duties) and, on the other, as "apathy," "anguish," "sadness," and "low spirits" (Jackson 1985:45). Here, the two behavioral and affective poles are explicit.

The concern for acedia changed. Originally seen only negatively as a sin, acedia acquired a positive meaning. This positive meaning derived from the view that the conditions of sadness and weariness were a result of one’s "penitence for sin" and/or one’s "desire for perfection" (p.48). These notions spread widely in Christendom beyond the clergy to the laity between A.D. 1200 and 1450, especially after the Lateran Council (1215–16) decided on the need to extensively disseminate penitential literature, clerical manuals (for the newly required sermonizing), and catechetical handbooks (Jackson 1985:48; Wenzel 1960).

The penitential literature spread the new benevolent view of acedia and tristitia, a term used interchangeably with acedia. In this view acedia, because it was a condition that afflicted only the devout penitent, seems to have become thought of as a form of penance itself (Jackson 1985; Wenzel 1960); that is, dejection was the penance of the devout. Penance was seen "as medicine for the soul" (McNeil and Gamer 1938:44). The most common governing medical principle of the time held that "contraries cured contraries" (Jackson 1985; McNeil and Gamer 1938). (One is reminded here of homeopathy's dictum, "Like cures like.")

Jackson points out how acedia and tristitia gradually lost their theological affinities, and the positive and negative connotations became part of the culture area's secular/philosophical theories of emotions. They later appeared in the context of medicine. The component of positive sorrow "became more identified with the Christian tradition of the sufferer as an object for care, concern and cure" (1985:53–54). The conception developed further into melancholy as the Church lost its explanatory powers over human behavior and, subsequently, there developed a renewed interest in classical writers. This Renaissance brought forth melancholy as both a medical term for an illness (Menninger 1963) and as a popular term referring to sadness (Jackson 1985).

The popular term referring to sadness also developed an association with the term (from Aristotle) melancholia and was subsequently associated in Latin countries with the very bright and the gifted; melancholy and brilliance were seen as dispositional companions. It is possible to see this association as late as the last century in France. There, and then, one saw frequently the association of the intellectual and the experience of sadness and/or sad, wasting diseases such as tuberculosis. This was the romantic vision of the pale, wan (tubercular) artistic intellectual (e.g., see Sonntag 1977).

This history, brief as it is, provides us with some understanding of the meaning of dejected states and dyshoria in French culture and history. The meaning of such states, their positive value, and their cultural significance, make us understand better the existence and elaboration of related sickness conditions in popular culture and in that culture's professional ethnomedicine. The ethnomedicine is an expression of that tradition.

Acdedia and tristitia evidently are the source of fatigué and triste/fatigué tout le temps and probably spasmodhils, as well. Elsewhere in Latin America, one finds the folk disorder of sadness called tristitia. The two poles or faces of acedia are well-preserved in contemporary medical and popular discourse with the mental/affective face presenting as triste while the behavioral face appears as fatigué in the alternate names of the contemporary disorder, triste/fatigué tout le temps. Spasmodhils and fatigué may themselves represent these same two faces and suggest a dualism with many forms in French culture. As well, this dualism appears in other Latin and
Mediterranean countries because the history of acedia, and the other cultural forms of despair, is shared with them and with many U.S. ethnicities.

Here we see the historical development of folk theories which later appear in biomedicine. Other, less historical works have also shown the presence of what I have termed "folk theories" in U.S. professional ethnomedicine (e.g., Brandt 1978, 1985; Cassedy 1984; Gaines 1979) as well as other professional ethnomedicines in Germany (Maretzki and Seidler 1985; Maretzki, this volume; Townsend 1978; Verwey 1985), England (Helman 1985), Greece (Blue 1991, this volume), and Canada (Lock 1985; Katz 1985, n.d.). The impress of culture on the biomedicines of Asia generally also has been noted earlier (e.g., Lock 1980; Ohnuki-Tierney 1984; Reynolds 1979; Weisberg and Long 1984).

The disorders considered here are seen in France as biologically based disorders, though their etiology is psychosocial. In fact, we see a slightly different notion of human biology and its relationship to thought and experience than found in the United States. States of the body, fatigué and spasphilia, both express and embody culturally constructed existential conceptions. Multiple, diverse physical symptoms are to be understood as expressions of unhappiness, loss, and disappointment. In this, the body is an expression of the mind; and this is not unusual (i.e., "somatization" in U.S. psychiatry), but rather normal, customary, and expected in lay and professional circles in Mediterranean (and New World Latin) lands. Finally, we note here that these disorders, along with crise de foie, appear to represent some of the 15 percent of French diagnoses that are not shared with other Western professional ethnomedicines (Helman 1990; Payer 1990).

Such differences have to do with an aspect of cultural history heretofore neglected, i.e., sickness history, which may be seen as the historical basis for thinking at the individual popular, folk, and professional medical levels in a particular culture. I suggest that cultures continue to thrive with their past in the medical domain by importing their particular repertoire of sickness histories into contemporary popular and professional (ethno)medicines. This historical process of continuity and importation is one means by which the demonstrable variation among the world's biomedicines is developed. Diseases, as elements of medical knowledge, may be seen in this way as products of sickness histories, not as products of current hypothesized material forces. A brief example from the U.S. will suffice to show the relevance of culture and sickness history for an understanding of biomedicines.

Sickness and Identity in America

In U.S. biomedicine, practitioners believe themselves to be focused on a universal, objective, external biology. In this biology, they find the source and focus of diseases, themselves objective, empirically evident, and universal (Mishler et al. 1981). However, if we explore the U.S. system of social classification, we will discover that much of the research and practice in biomedicine, including psychiatry, is not grounded in an objective, external natural biology but rather in a culturally constructed folk biology and folk genetics.

Systems of social identity are known to be based in culturally specific criteria of relevance. These distinctions are often articulated in terms of the "biology of race" (Bianchi 1980; Boas 1966; Domínguez 1977, 1986; Gaines 1980, 1986b). Here one finds the peculiar belief in, and social and economic institutions based upon, the existence of human "races," a form of social classification with virtually no empirical basis. Demonstrative of the lack of coherence of racial theories, one finds various classificatory schemes in use with varying criteria of differentiation including geography (e.g., "Asians," "Africans," "Europeans"), language (Hispanics), claimed skin color ("white," "red," "black," "brown," "yellow," etc.) and even religion ("Jews," "Christians," "Moslems").

Elsewhere, I have detailed the problematic of the notion of "race" in psychiatric clinical practice and medical research (e.g., Gaines 1980, 1982b, 1985a, 1986b, 1987), and therefore simply emphasize the obvious here, i.e., that such folk theories hold a prominent place in U.S. biomedicine, as do notions of gender. Theories of "race" and gender differences are both versions of a folk biological theory. Holders of such theories believe differences among the "races" or the sexes exist and are a result of biology rather than reflection, and the socially produced results of, their own prejudices. Apparently, these prejudices distort both cognition and perception, and should, therefore, logically find their way into psychiatric classifications, all things being equal (which they are not).

The deleterious effect on perception and cognition of racism is obvious, for example, in the common gross misrepresentation of biological reality encoded in the notion itself. For example, most Native Americans are biologically part European, in many cases largely so, and not infrequently, for southern Native Americans, part West African as well. And, virtually all U.S. blacks or "African-Americans" are biologically part European, and again in many cases largely so. And, again, quite commonly at least for southerners, they are also part Native American (Gaines 1985a, 1987, 1989; Hallowell 1976; Montagu 1962; Watts 1981). Examples of famous black Americans with known melanic antecedents as much or more from Europe and Native North America as from West Africa, include Charley Patton, the archetypal Delta bluesman, Muddy Waters, the 'father of electric blues,' Chuck Berry, the primary architect of rock 'n roll, and entertainer Eartha Kitt, among tens of millions of others.

As well, among individuals who are considered "white" and trace their ancestry back to early settlers in the American South, it should be pointed
out that such individuals have, as a virtual certainty, African (i.e., West African) ancestry and even more certainly have African-American relatives. (One family, the Hairstons, has recognized this fact and annually holds a family reunion which includes thousands of both “white” and “black” Hairston family members.) It is apparent that medical work considering biological differences among “blacks and whites” constitutes an U.S. cultural fiction in the context of an ostensibly empirical biomedical science.

While advocates of biological views claim that biology is the cause of homogeneity, evolutionary biologists, cognizant of the local nature of biology (and zoology or botany) resulting from local factors affecting reproduction, regard biology as the prime cause of diversity (Kleinman 1988; Rosenfield 1986; Watts 1981). As Rosenfield (1986:22) points out, “Qualities we associate with human beings and other animals are abstractions invented by us that miss the nature of the biological variation” (in Kleinman 1988:19). The construction of the science of biology in the last century has incorporated aspects of other fields and asserted itself. A self-evident, external reality which justified the delineation of a separate field of scientific endeavor was lacking; its contemporary presence as a separate discipline is then a constructed presence, not a reflection of a natural world (see Coleman 1987).

Research on the treatments of choice and treatment recommendations in U.S. biomedicine demonstrates that diagnostic and therapeutic choices are often made on the basis of patients’ social identity, whether it is “race,” class, or sex (see for example, Brandt 1985; Brill and Storrow 1960; Derogatis et al. 1971; Dorfman and Kliner 1962; Enright and Jaekle 1963; Harding and O’Barr 1987; Lock 1985; Myers and Schaffer 1958). For example, we find that in the United States of the last century the use of anesthesia after its introduction was based on racial and gender stereotypes (Pernick 1985). Today, the determination of appropriate patients for heart bypass surgery and even postoperative pain medication is based on gender stereotypes (Tohin et al. 1987). The form of intervention in psychiatry, pharmacotherapy, or psychotherapy is likewise today largely dependent on stereotypical attributions of “racial” and sexual identity rather than on putatively empirical psychiatric signs, symptoms or diseases (e.g., Neighbors et al. 1989; and see MacKinnon and Michels 1971).

Social identity has implications for clinical care and medical research. In psychiatry “Blacks” and Hispanics are often seen as “not psychologically minded” or as belonging to that group of patients termed “psychologically unsophisticated” (MacKinnon and Michels 1971). Because of this classification, somatic, including pharmacological agents, are seen as treatments of choice. U.S. biomedicine’s division of the social world into “races” is unique to it and expresses its cultural context. While other cultures have notions of “race,” they are distinct from that found in the United States (e.g., Japan, South Africa, China). The U.S. version of folk biogenetics assumes behavioral, and/or biological homogeneity within categories and assumes the categories to be reflections of nature rather than culture. As a result, we find that pharmacological (e.g., Lin, Poland and Lesser 1986), epidemiological (e.g., Holden 1991; Sommerville et al. 1989; Vernon and Roberts 1982), as well as biomedical practice is conducted and interpreted in these putatively natural biological/genetic terms. Research in France on social classification, however, shows us that the social world there is divided according to very different, cultural criteria.

Social Classification in France: the Contrast

Research on French social classification in Strasbourg (1974, 1981–3), the capital of Alsace, the most eastern province of France, revealed two distinct systems of classification, one French and the other Alsatian. The latter is, in fact, merely a variation of folk German theories of social classification, as Alsatian culture is one of German culture’s (not the State of Germany) daughter cultures. (See Gaines [1978, 1980, 1985c] for detailed analyses of social classification, including religious identity in Alsace.)

French ethnic identity is symbolized by culture, primarily in the form of language competency. Thus, anyone, regardless of “race” can become a French ethnic, physical appearance is not germane. (Apparel can be, as it can indicate a rejection of French culture (“civilization”) as one sees today among some Arabic speakers and historically among some Orthodox and Hassidic Jews. Such people are the targets of the right wing in France.) As a consequence, one does not find hyphenated French people; one is French or one is not. In my research I have met people who, in the U.S., would be called Vietnamese-, Greek-, Italian (i.e., Friulian)-, African-, Japanese-, Moroccan-, or Armenian-American(s). But, in France, they were all considered by self and others as French ethnic.

In contrast to the means of acquiring French identity, one can only be born an Alsatian (or German) ethnic. To claim an Alsatian identity, one must have a known lineal antecedent who was or is Alsatian. Hence, one cannot assume the identity regardless of language competence, religion, residence, marriage, or appearance; one simply cannot become Alsatian. Among Alsatians, we find a racial theory that states that people are what they are because of their “blood” (blut), which is inherited. Therefore, individuals who are seen as phenotypically different, but who in fact have Alsatian ancestry, may be rejected as Alsatian ethnics. Informants from other lands (India, Africa, Asia) tell me that in Alsace, “they are a bit racist,” but do not say this of the rest of France. These facts suggest the cultural basis of affiliation and of biology and genetics as used by this group; they constitute an “ethnobiology” and an “ethnogenetics.”
We see two theories of cultural belonging, one cultural and one biological. We note, however, that the biological conceptualization of the Alsatian, and its parent Germanic tradition, is a folk biology and a folk theory of genetics and inheritance. The notion of biology as the key to psychiatric differences is in fact of German origin and comes directly from Krapelinian German psychiatry (Gaines 1992; Young 1988), and today may be found in both medical and popular domains (Townsend 1978).

The social world of France is classified in ways which are not comparable with American social classification. As a result, the clinical practices and research found in America based upon American notions of "race" are peculiar to U.S. medicine (see Farmer, this volume). However, I do not suggest that the French neither make invidious distinctions nor hold communalistic views. Rather, I suggest their criteria and categories are different.

Biology as Key Symbol

These brief observations suggest that particular forms of communalism play a large role in U.S. medical ideology, practice and education (Brown 1979). Biological notions such as "race" and gender differences in U.S. medicine have evolved with U.S. social history and as such are part of the sickness histories of the United States which are not shared with France. In the same biological vein, one notes that writers concerned with women as subjects and objects of medical practice in the U.S. have shown the falsity of the assumptions or the assertions of the neutrality of biomedical knowledge and practice as regards women, thereby demonstrating the sexist nature of biomedical theory and practice (see Barrett and Roberts 1980; Brandt 1985; Harding and O'Barr 1987; Lock 1985; Tobin et al. 1987).

We can but mention the development of slavery, immigration of various ethnic groups in this and the last century, and the suffrage, labor, and civil rights movements to bring to mind the social history of communalism in the U.S. Communism is intrinsic to U.S. medicine because of its culture's social history. It contributes to making U.S. medicine uniquely American, not in the sense of an evil empire set apart and opposed to society or to culture, but as an expression of that culture and its history. As a cultural medicine, it may be criticized both from within and without the cultural tradition by those it fails to serve and those it serves to fail.

In expressing culture history, medicine's key concept, biology, serves as a key symbol (Ortner 1974). As Ortner explains, key symbols serve to unite disparate yet related cultural elements and to summarize central themes of culture. The biological, then, appears in part as a product of culture history and is symbolic not of universal realities but of the particular histories of France and the U.S. Biology as symbol is as much a reflection of culture history as of nature (the symbolic character of which also may be shown) (see Gordon 1988).

Biology as key symbol provides a sense ofSelbstverständnis (self understanding) of biomedicine as a group and for its member individuals. It also seems to serve to establish self-esteem and social stature within and outside of medicine; biology is the focus of the subculture’s work and the basis, and therefore validation, of its asserted scientific, value-neutral theory and praxis.

Biology serves, too, as the criterion of ranking in the status system; it appears that the greater the possibility and extent of somatic intervention, the higher the status within U.S. biomedicine (see Johnson 1985). The context of practice, hospital or not, is the chief, but not the only, criterion in the status system of France.

In relating biology to technology, we find that technology is the tool which allows greater access to and manipulation of the biology of the patient. Hence the "discourse of competence" among physicians is found to be related to reputed mastery over new technology and greater biological knowledge of one physician over another or others (DelVecchio Good 1985), or of one medical specialty over another (Johnson 1985).

Historically we see that U.S. biomedicine self-consciously allied and identified itself with the biological sciences and with (French) statistics in the nineteenth century in order to appear scientific (Cassedy 1984) after having moved away from the identity of medicine as art under the influence of Rush. The new pose allowed practitioners to assume a valued identity, that of modernists (i.e., scientists) who were involved in "progress." (The idea of progress in medicine is another important symbol deserving analysis.) There developed, then, a "cloak of scientific competence," through which U.S. medicine began to emphasize research and relate it to clinical practice, again under French influence, only sometime after the Civil War (Leach 1984).

Despite its scientific pose, biomedicine did not eliminate its nonbiological nineteenth-century adversaries; it incorporated them. Aspects of homoeopathy, hygiene, homeopathy, and Thompson's botanics became part of U.S. biomedicine as did the Russian notion of medical heroics. (Then as now the results were sometimes detrimental to the patient, as for example, the fact that the physician's assumption of the role of hero was often fatal to patient. The role of hero can still be seen in contemporary surgery and internal medicine [see, for example, Hahn 1985; Katz 1985, n.d.].)

Biology serves to unite disparate cultural themes, such as "professionalism, competence," (both deriving from Lutheran theology), scientism, "progress and objectivity." It also serves to summarize them. It serves as the focus and validation of medical work and establishes group and self-identity. But there are, as noted here, local and contextual variants for the meaning of the key symbol. Its polysemous nature provides it with a resilience which allows it to endure in the face of important criticisms about the value and utility of the biological perspective in dealing with human suffering.
This symbolic potency is adopted by contemporary psychiatrists who view their work in biological terms. This stance has increasingly come to dominate psychiatry since the introduction of the major tranquillizers, i.e., antipsychotics, in the 1950s (Kleinman 1988; Johnson 1985; Lin, Poland, and Lesser 1986). Biological psychiatry, which treats of the biological and locates the nosological entities of its clinical interest in biology, is seen as the “new psychiatry” and as the means by which psychiatry will raise its status within medicine and become part of “mainstream” medicine. The criteria of evaluation are not necessarily efficacious practices. Again, we see the symbolic meaning and use of the biological.

Conclusions

The contextually variant meanings of biology and other symbols of biomedicine need further examination if we are to unravel their condensed, multivocal meanings. The present paper has sought to provide some tools for the interpretive analysis of biomedicines. The notion of sickness history, as a component of culture history, was advanced as a useful device in identifying and understanding differences in French and U.S. biomedicines. Aspects of the meaning of biology in the two systems were shown to derive from culture history, not current social forces or relations.

We have seen that biology, the body, in France is a mode and expression of experience (see Caordas, this volume). In the United States, it tends to serve, among other things, as the putatively empirical basis for social classification. On that basis, practices are generated. The French illness would be seen as illegitimate, as “only” psychosomatic illnesses and, doubtless, as malingering in the United States. Conversely, the “racial” system of social classification used by U.S. science and society would likewise be rejected in France. But, both are believed to be grounded in a biology and are therefore quite “natural,” or so it is assumed.

The biomedicines, then, appear not to be monoparadigmatic, though they often strive to present themselves as such (Engel 1977; Mishler et al. 1981). In regard to the notion of biology as symbol rather than as an ultimate reality, it is important to note that other professional medicines exist which, while biologically based, articulate distinct biologies, e.g., the professional ethnomedicines of India, China, and Japan. The view presented here is that professional ethnomedicines are, to paraphrase Evans-Pritchard, moral systems, not natural systems. They represent “local biologies.”

I have tried to offer a view of professional Western biomedicines as cultural garments woven not of a single fabric, but of many. The cloaks which cover biomedicines conceal, yet embody, express, and perpetuate the existence of distinct threads of vital histories of conflict and accommodation. It is suggested here that biomedicines in anthropological research should be taken less for their monoparadigmatic, idealized biological con-

Medical-Psychiatric Knowledge in France and the United States

...tenances and more for their multiparadigmatic cultural realities—realities created and grounded in local cultural knowledge and history.

Acknowledgments

I would like to thank Drs. Allan Young and Arthur Kleinman, and Lisa Mitchell and two anonymous reviewers for helpful comments on drafts of the present paper; thanks to Sue Wasserkrug for editorial assistance. Any problems which remain do so in spite of their best efforts.

Notes

1. The label “bourgeois medicine” has been advanced by Singer (1986). This label serves to convey the ideology of its users rather than anything about the object of study. It reflects a problematic view of biomedicine as universal, monolithic, distinct and set apart and opposed to society and produced by an economic system (also see Wright and Treacher 1982a on this point).

2. This research was conducted in Paris and Strasbourg in the summer of 1982 with Paul E. Farmer while we were both at Duke University. A Duke University Major Grant funded the research.

3. Psychiatrists queried include some at Duke Medical Center, 1983, and Case Western Reserve University School of Medicine, 1984-87.

4. As a result, through the 1970s, 61 percent of French physicians were general practitioners while only 39 percent were specialists. In the United States, we find a striking difference with only 21 percent of active physicians in general practice and 79 percent in specialties (USDHHS 1983:6). This difference is a reflection of the very different nature and context of medical practice in France and the United States. It also reflects a very different notion of intelligence in the two countries. It is also relevant to point out that many medical specialties in France and the United States are not comparable. There are, as well, very different social organizations of medicine in the two countries, different bases of hierarchy, hospital privileges, use of physicians as sources of help and the usual site of patient healer contacts (Bassanger 1985; Cabridain 1985; Du Pouvoirville and Renaud 1985; Katz 1985, n.d.; Johnson 1985; USDHHS 1983). Other major differences include care of the elderly and use of pharmaceuticals (Gaines n.d.; Lenoire and Sander 1976).

5. My original year-long study in Strasbourg (1974) was funded by an NIMH training grant. Subsequent visits (in the early 1980s) were funded by Duke University Major and Minor Grants.

References

Abu-Lughod, Lila

Ackerknecht, E. H.
American Psychiatric Association

Apple, Dorian

Baer, Hans, Merrill Singer and John Johnson

Bailey, F. G., ed.

Barrett, M. and H. Roberts

Bassanger, Isabelle

Becker, H., B. Geer, E. Hughes and A. Strauss
1961 The Boys in White; Student Culture in Medical School. Chicago: University of Chicago Press.

Blu, Karen

Blue, Amy V.

Boas, Franz

Boek, Charles

Brandt, Allan

Brill, N. and H. Storrow

Brown, E. Richard

Medical/Psychiatric Knowledge in France and the United States 193

Cabidina, Marie-Odile

Campbell, John

Cassidy, James

Coleman, William

Cornellisen, Ann

Crapanzano, Vincent

Davis, John

Derogatis, L., et al.

Dodier, Nicolas

Domínguez, Virginia

Dorshman, D. and R. Kliner

Douglas, Mary

Dugan, Anna Basiak

Eickelman, Dale

Eisenberg, Leon
Engel, George

Enright, John and Walter Jaeckle

Frankenberg, Ronald

Freidson, Eliot

Foster, George and Barbara Anderson

Foucault, Michel

Foukula, E., D. Freeman, F. Kaslow, and L. Madow

Gaines, Atwood D.


n.d. Physicians and Pharmacy in France. ms.

Gaines, Atwood D. and Paul E. Farmer

Gaines, Atwood D. and Robert A. Hahn, eds.

Gaines, Atwood D. and Robert A. Hahn

Ceertz, Clifford

Gilmore, David

Good, Byron

Good, Byron and Mary-Jo D. Good

Good, Byron, Mary-Jo D. Good and Robert Moradi

Good, Mary-Jo DeVecchio
Medical/Psychiatric Knowledge in France and the United States

Katz, Pearl

t.d. The Active Posture of Surgeons. ms.

Kleiman, Arthur

Kleiman, Arthur, Leon Eisenberg, and Byron Good

Koos, E. L.

Lee, Dorothy

Lehoux, C. and S. Sandler

Lesch, John E.

Leslie, Charles, ed.

Letourmy, Alain

Lin, K.-M., R. Poland and I. Lesser

Lock, Margaret

Luts, Catherine

MacKinnon, Roger and Robert Michels
Maretzki, Thomas

Maretzki, Thomas and Eduard Seidler

McNeill, J. and H. G. Cramer

Menninger, Karl, Jr.

Merton, R., R. G. Reader and P. Kendall. eds.,

Mishler, Elliot, et al.

Montagu, Ashley

Myers, Jerome and Leslie Schaffer

Navarro, Vincente

Neighboors, H., J. Jackson, L. Campbell and D. Williams

Obeyesekere, Gananath

Ohnuki-Tierney, Emiko

Ortner, Sherry

Parsons, Talcott

Payer, Lynn

Perris, John, ed.

Pernick, Martin

Pitt-Rivers, Julian, ed.

Piskin, Karen

Pouvoir, Gérard Du and Marc Renaud

Rabinow, Paul and William Sullivan, eds.

Reynolds, David

Rhodes, Lorna Amarasingham

Rosenfield, I.

Rudel, Arthur

Schepker-Hughes, Nancy

Singer, Merrill

Sommervell, P.D. et al.

Sontag, Susan

Starr, Paul

Taussig, Michael

Tobin, Jonathan, et al.
Toussignant, Michel
Townsend, J. M.
Turner, Victor
United States Department of Health and Human Services (USDHHS)
Vernon, S. and R. Roberts
Verwey, Geerlof
Waiszkin, Howard
Watts, E.
Weisberg, D. and S. O. Long, eds.
Weiss, George
Wenzel, S.
Wright, Peter and Andrew Treacher, eds.
Wright, Peter and Andrew Treacher
Wylie, Laurence
Young, Allan