

The Cultural Psychology of Suffering: The Many Meanings of Health in Orissa, India (and Elsewhere)

Richard A. Shweder

Abstract In this article, I honor Jerome Bruner's meaning-centered and person-centered approach to the study of cultural psychology by describing aspects of the cultural psychology of suffering in and around a Hindu temple town in Orissa, India. I also outline the "big three" explanations of illness (biomedical, interpersonal, and moral) on a worldwide scale and recount some of the many meanings associated with the word *health*, as in the English language survey question "How would you rate your overall health?" [cultural psychology; explanations of illness; meanings of health; Orissa, India]

Jerome Bruner is famous for his meaning-centered and person-centered approach to the study of cultural psychology (see, e.g., Bruner 1986, 1990, 1993).¹ In this article, I seek to honor the life and work of my former teacher with a thickly substantive (and partly analytic) article on the many meanings of health for people in Orissa, India, where I started conducting research on cultural psychology while still a student taking courses with Jerome Bruner at Harvard University during the late 1960s.

Before fully engaging my topic—the cultural psychology of suffering—allow me to glance back a few decades and share a pleasurable memory. At Harvard University in the late 1960s, the Department of Social Relations (where I was a student in the "Social Anthropology Wing") and the Department of Psychology (where Jerry Bruner was a faculty member and the director of the "Center for Cognitive Studies") were located in the vertically and intellectually segmented white towering structure, William James Hall. One is tempted, while thinking back on those glorious days and on that strange setting, to write an article entitled "William James, Floor by Floor." If you were looking for personality and clinical psychology (in those days, Henry Murray, Eric Erikson, David McClelland) you pressed the number 15 elevator button. Talcott Parsons and his sociological theory were located on floor 3. Beatrice Whiting and John Whiting, Evon Vogt, Cora DuBois, the Human Relations Area Files (HRAF), and much of cultural anthropology could be found on the fourth floor. Each floor felt like its own intellectual world. I lived on Floor 4, but every once in a while I would enter the elevator and press 11; and with great anticipation and excitement I would enter the world of Jerome Bruner, George Miller, and that Center (for Cognitive Studies) that was a launching site for what came to be known as "the cognitive revolution."

The anticipation would be for one of those coveted and intellectually challenging 15-minute appointments with one of the greatest founders of the cognitive revolution, and a scholar who knew how to think and write with both his right and left hands.

"Enthusiasm" may have been viewed as heresy during the European Middle Ages but not in Jerome Bruner's office. Then as now his analytic brilliance was dazzling, his mind was generative beyond belief, and his intellectual pace breathless. A 15-minute appointment would typically have the following shape: three minutes of suggestions about how best to carry forward current research projects, providing more than enough creative guidance to keep one thinking for years, interrupted by incoming phone calls from all over the world (was that Jean Piaget on the other side of the line, or perhaps Noam Chomsky?), which in turn might be interrupted by a knock on the door from his Harvard colleague George Miller or from any of the many young luminaries (perhaps Mary Potter or Colin Trevarthan) who were resident scholars in "Cognitive Studies" that particular year. To sit in his office for just a few minutes was to have the sense that one was at the center of something big: that all the fields in the human sciences (psychology, linguistics, philosophy, anthropology) were going to be brought together and integrated right before your eyes. So I was fortunate to have experienced those appointments on the 11th floor in William James Hall, and to have witnessed that intellectual ferment.

Indeed, I was triply blessed. My second piece of good fortune was to have taken the course of all courses in the Department of Social Relations in those days: a lecture series for both advanced undergraduates and graduate students called Social Relations 148 (Cognitive Psychology). Jerry Bruner was the lecturer and his range of topics was vast: Vygotsky, Piaget, motor movement, the orienting reflex, voluntary action, theories of categorization, the problematic distinction between percept and concept, modes of representation, cultural differences in modes of thought, the workings of the body in relation to the workings of the mind. Ken Kaye and Jerry Anglin were the teaching assistants. Alan Fiske and John Miyamoto were undergrads in the course. I attended as a graduate student. Some years later, Ken Kaye was my faculty colleague at the University of Chicago and Alan Fiske became one of my first Ph.D. students in the Committee on Human Development (renamed recently "Department of Comparative Human Development"), while John Miyamoto went on to become a psychologist and methodologist at the University of Washington and a lifelong friend. In other words, an intellectual community began to take shape right there in the lecture hall in the basement of William James Hall. The course added character and substance to the abstract idea of Jerome Bruner as a Harvard Professor; brilliant, dazzling, and always and everywhere in a breathless and breath taking state of physical and metaphysical motion.

My third piece of good fortune was to have witnessed the very beginnings of Jerry Bruner's disillusionment with "the cognitive revolution." He was one of its great founders yet he noticed early on that the revolution had taken a fatal turn: it had become too structural, too formalistic, too much concerned with "deep structure," too little concerned with meaning and narrative, with ordinary communication and person-centered, lived experience. In the

mind of Jerome Bruner the idea of a meaning-centered and person-centered “cultural psychology” was about to be born. How fortunate for those of us—anthropologists and psychologists—who studied, worked, and sometimes even lived in William James Hall in the late 1960s, and who went on to do work in cultural psychology seeking to contribute to the success of its current revival. How fortunate (and astonishing) that 40 years later we are able to say “thank you” to our mentor and to honor his work, life, and spectacular career.

Where there is a human mind there is a meaning maker. Meanings are all the ideas or notions that stimuli, responses, events, or objects imply, suggest, or signify to someone capable of being a meaning maker. Meanings mediate the connection between stimulus and response; hence, an unmediated stimulus (the pristine thing, in and of itself, as a “noumena”) is neither a necessary nor a sufficient condition for a response. Moreover, where there are many human minds living together there are traditions of historically made, normatively endorsed and received meanings; that is to say, across time and space there are and have been many durable and locally credible ways to picture and value the world. It was with those two basic Brunerean lessons in my mind that I took my first “journey to the East.” There (in South Asia) and then (in the summer of 1968) I began the process of learning to picture and value the world somewhat differently, in the variety of ways that are readily available to devout and practicing Hindus in the corner of India (the temple town of Bhubaneswar in Orissa, India) where I do research. What follows is one small product of that process, an account of the cultural psychology of suffering, inspired by Jerome Bruner’s lectures on cognitive mediation and by fieldwork experiences in South Asia.

The Meaning of Things: Some Hazards of Cross-Cultural Communication

In India it is widely believed that the mouse is afraid of the Elephant God Ganesh, while in the United States it is the folklore that elephants are terrified of mice.

In India, at least among the rural Oriya Hindus I know best, the owl is believed to be an inauspicious bird, an unkempt predator that viciously slaughters the crows who bear the spirits of ones ancestors during the *sraddha* ceremony (honoring seven generations of deceased kin), and it is a curse to tell a married woman that she will be “reborn as an owl,” while in the United States it is legendary that the owl should be admired for its wisdom, as if a sage.

In the United States it is polite to say to a postpartum mother nursing a child “what a beautiful child that is;” while in India that particular remark, which Americans consider so salutary and beneficent, is used by Kalisis and Devi Sadhaks and other mediums of the great goddess of Hinduism to diagnose sorcery and the evil eye; and that comment, which Americans consider so affectionate and nice, is believed to cause fever, diarrhea and vomiting in infants.

In India even the most enlightened of medical scientists will tell you that "religion is observed for better health," while in the United States, at least among those who view themselves as "enlightened," the very idea of "religion" is opposed to ideas of "science" and "medicine," and such notions as "atma," "preta" and "chuan" ("soul," "ghost," "ritual pollution") are associated with darkness, superstition, irrationality, and an antique or premodern cast of mind. One of the surest ways to bring a dinner party to a halt on the Upper West Side of Manhattan or Bethesda, Maryland, is to speak earnestly about the "soul" or to use the word *God*.

In the United States, the current historical age is sometimes dubbed the "age of reason." Many contemporary Americans tend to "officially" believe (their politicians and scientists certainly talk this way) that technological progress abounds in their country and that because of their physical and biological sciences Americans are about to seize control of nature and become the most advanced and the most knowledgeable human beings who have ever lived. While in India, even among many politicians and scientists, the age of truth (Satya Yuga) is thought to have existed long, long ago and the stories of the old time (the Puranas and the Epics) are the preferred standard for judging contemporary decline into an age of ignorance and darkness known as Kali Yuga.

With a sense of loss and with Kali Yuga very much on his mind a brilliant Oriya Indian friend once told me:

There is nothing on the outside called God. God is within us. The human body is the only real sacred ground and it becomes de-sanctified after pollution. If your life-span is fifty years it will decrease if you allow your body to become polluted. But if you obey every duty and custom you will be free of pollution and you will be healthy. Nowadays if someone suffers from fever or illness they may be prone to say that they suffer from an infection. They do not believe in pollution and the other causes. It has long ago been written that during the days of Kali Yuga people will abandon their traditions and only think this way. [Excerpted from interviews conducted in Orissa, India, 1982–83]

I mention these striking contrasts between India and the United States because when scholars, scientists, and intellectuals from two intellectually sophisticated but distinct cultural traditions come together at a workshop to discuss "Traditional Medicine and Mental Health" (see "acknowledgments"), wisdom cautions sensitivity to the hazards of cross-cultural translation and (mis-)communication. Every one of the words in the official title of that workshop, with the possible exception of the term *and*, is likely to connote a somewhat different set of meanings on each side of the hyphen in the welcoming phrase "Indo–U.S.A."

I mention those differences in the meaning of things in these two lands because the metaphysical jet lag of a long journey in either direction between India and the United States is likely to be far more severe than the physical jet lag. I mention them because the ingestion of melatonin will not work as a cure for the subtle misunderstandings likely to arise when English words such as *traditional*, *medicine*, *mental*, and *health* get used as though a common

language. In fact, such words evoke somewhat different pictures of the world in the minds of speakers from different intellectual and cultural traditions.

For example, years ago when I first started doing research in the Hindu temple town of Bhubaneswar in Orissa, India, my Oriya colleagues would sometimes say to me “She is a very shy girl” as a way of recommending a student as a research assistant. What they did not realize was that that is definitely not the way to recommend someone for a job (or anything else) in the United States. In the United States the word *shy* implies meekness, timidity, insecurity, and weakness (not to mention such culture-specific and disparaging nonhuman animal metaphors as “sheepish” and “mousy”).

What I came to realize at the time was that bilingual Oriya-English speakers use the English word *shy* as a translation of the Oriya word *lajya* (or *lajja*). There really is no adequate single lexical translation in American English for the Oriya word *lajya*, although the paraphrase “a civilized person who displays the emotion and virtue of respectful self-restraint and gracefully submits to the authority of others” captures its meaning far better than the word *shy*. During the pre-Victorian period in England the novelist Jane Austin knew all about the concept of “lajya” or “respectful self-restraint,” but it is a relatively dormant and unacknowledged emotion and virtue in the United States today (Menon and Shweder 1994, 2003; Shweder 2003a; Shweder and Haidt 1999). So when my Oriya colleagues said “you should hire her,” in their minds the word *shy* (as the translation of *lajya*) was meant to imply unpretentious, not brazen, having a sense of propriety and humility, self-restrained, elegant, decent, and good (Menon and Shweder 1994; Shweder 1996, 2003a). I discovered in the case of “she is a shy girl” that to use the same words is not necessarily to speak the same language. I discovered that if you want to learn about other peoples’ meanings for things it is essential to be aware that the appearance of shared understanding can be an illusion.

Traditional Medicine Compared to What?

I suspect the same problem of hazardous cross-cultural translation and communication will arise in Indo-U.S.A. discussions of traditional medicine and mental health. On each side of the hyphen in “Indo-U.S.A.” some apparently transparent English words (*health, medicine, mental, traditional*) will be associated with a somewhat different picture of the domain to which the word is thought or meant to refer.

Consider, for example, the phrase *traditional medicine*. In the context of the two major Western intellectual traditions with which I am most familiar, “enlightenment modernism” and “counter-enlightenment romanticism” (Shweder 1984), that phrase almost inevitably suggests some kind of contrast or opposition between “modern medicine” (equated with Western “allopathic” medicine) and “traditional medicine” (equated with everything else), typically to the denigration of the one or the other.

There are of course many intellectual cross-currents in the United States today (some more dominant or salient or well-publicized than others), just as there are in India. Nevertheless, in most of the discourse on this topic *traditional medicine* gets used as a way of contrasting Western allopathic representations of biological disease processes to something else (indeed to anything else). The "anything else" is called *traditional medicine* (although the phrase *alternate medicine* has come into vogue, in large part because of efforts at the U.S. National Institutes of Health). Thus, within the United States *traditional medicine* often takes on the meaning "health doctrines and practices which are not 'Western allopathic medicine'"; and the phrase is used to refer to a vast and heterogeneous collection of theories and therapies, ranging from alternative representations of biological causes of suffering (e.g., Ayurvedic theories about the "dosas" or humors of the body) to transcendental meditation to forms of Christian charismatic spiritual healing.

Among enlightenment modernists that particular scheme of interpretation (modern = Western allopathic medicine, traditional = everything else) plays itself out as follows. Western allopathic medicine is modern, not traditional. A series of oppositions is invoked; traditional is to modern as darkness is to light, as superstition is to knowledge, as backward obsolescence is to the advanced cutting edge, and so forth. Thus, at least among enlightened modernists in the United States, *traditional medicine* gets used as code for pseudo-healers who are charlatans and quacks, in contrast to modern healers who have supposedly transcended both darkness and tradition, thereby gaining objective access to the truth.

Parenthetically, it is important to note that most enlightenment modernists do allow that at least some so-called traditional medicine has been mislabeled and that some of it is really modern medicine in disguise. Consequently, most enlightenment modernists are open to the possibility that at least some so-called traditional healers are effective therapists practicing modern medicine, albeit unknowingly and without intent or license.

Moreover, enlightenment modernists can be quite entrepreneurial about the chemistry and salubrious properties of the roots and shoots of the jungle. There are private companies in the United States (e.g., Shaman Pharmaceuticals, Inc.) who are well aware that approximately 150 drugs (from digitalis to quinine) have been synthesized from medicinal barks, roots, and leaves of so-called traditional healers. These companies invest heavily in the acquisition and laboratory analysis of natural substances utilized by so-called traditional healers around the world. Their aim is to isolate component chemicals and then license them with the Food and Drug Administration of the U.S. Government (the FDA), thereby upgrading the status of so-called traditional therapies by officially certifying them as "modern medicine." It is noteworthy that neither Shaman Pharmaceuticals, Inc., nor the FDA invests in "placebo cures," although perhaps that will change.

Although enlightenment modernism is a strong voice in the West, another voice can also be heard in the United States these days, the voice of counterenlightenment romanticism. When it comes to the contrast between traditional medicine and modern medicine,

counterenlightenment romantics typically reverse the direction of darkness versus light. Counterenlightenment romantics are thereby, in the context of contemporary scientific and political debates in the United States, vulnerable to the accusation of being “soft on superstition.”

To counterenlightenment romantics the very idea of “traditional” medicine suggests something old, venerable, “natural,” good, and useful, and it does so precisely because traditional medicine is seen as an alternative to so-called modern medicine. Guided by the lights of “tradition” counterenlightenment romantics hope to recapture what modern medicine has lost, a mature understanding of the mental side of somatic experience and of the whole person as a psychological, social, and political being. Counterenlightenment romantics hope to resist the specific version of biological representation and therapeutic practice (e.g., the reductive idea of autonomous biological disease processes, excessively potent synthetic drugs, and invasive surgery) associated with mainstream biomedicine in the “West.”

Notice however that both intellectual traditions (enlightenment modernism and counter-enlightenment romanticism) presuppose mainstream medicine as currently institutionalized and empowered in the West as *the* reference point for defining what counts as traditional. For both camps, the very idea of “traditional medicine” is something that is defined by contrast to the contemporary Western mainstream. For better or worse, this seems like a rather ironical and parochial way of defining ones terms, where the only way to be modern is to be part of the mainstream, and the only mainstream that counts is the one that runs through the West.

From Traditional Medicine to Traditions of Medicine

One of my aims in this article is to shake myself free of this type of thinking. During the years I have spent documenting and writing about family life and social practices in India I have learned many things from doctrines, customs and habits of mind that have grown up and/or thrived on the sub-continent of Bharat (Menon and Shweder 1994, 1998; Shweder 1991, 2003b; Shweder et al. 1990; Shweder et al. 1997). One of the things I have learned is that in South Asia (more specifically, in rural India; even more specifically in rural Orissa, India) there is no special privilege accorded to Western allopathic medicine. In the region of India in which I work (coastal Orissa, in and around the temple town of Bhubaneswar), Western (allopathic) medicine is highly respected for treatment of certain ailments in adults, but it is respected as only one worthy tradition of medicine among many.

To anyone familiar with the South Asian cultural scene, this should come as no surprise. Given the contemporary and quite luxurious metaphysics subscribed to by hundreds of millions of Hindus in rural India, when suffering occurs the diagnostic situation is complex. For one thing, there is not just one world to deal with but three: the society of the gods (who

are a major presence in almost every household and community), the society of the spirits (*preta loka* and *putri loka*; who are also a major presence in almost every household and community), and the society of human beings. Second, these three worlds interact in a universe governed by principles of dharma (truth, righteousness, duty, responsibilities of station) and laws of karma (the idea that for every action there is a just or proportionate reaction; the idea that it is natural, moral, and inevitable to reap what you sow).

Thus for any physical or mental difficulty there are many possible causes. The difficulty might be because of infection, disruption of the humoral (*dosa*) content of the body, a result of karmic debt related to a transgression of duty in this and earlier lives, or associated with pollution of one's sacred body or by the unwelcome, even if temporary, influence of one of the nine malevolent planets. The difficulty might be caused by a curse from an envious neighbor or by the influence of some evil spirit. Perhaps a *chandi* (an unworshipped goddess) or a *bhuta* (the ghost of someone whose cremation process went awry) or a *chiriguni*, *pichasuni*, or *brahmarakyas* (in each case the lingering and discontented spirit of someone, a pregnant woman, a Brahman, who died suddenly, scandalously, or without satisfaction of his or her desires) has been sent by a *guni* or *tantric* "magician" to cause harm, to attack somatic or mental functions or to invade the body and take over or confuse the will.

Moreover, given this complex yet compelling picture of the potential causal forces of nature the domain of plausible healers grows large. It includes allopathic doctors, homeopaths, Brahman priests, *baidyas*, *kabirajs* and other ayurvedic doctors, *kalisis* (devoted mediums of the Goddess), *ojhas* (astrologers), *poorthis* (oracular consultants of palm-leaf manuscripts who can identify transgressions in past lives), *devi sadbaks* (agents of the goddess who are able to diagnose true causes of illness by means of *pranayam* [meditative breathing]), and many others.

The range of plausible therapies is equally diverse. It includes antibiotics, herbal medicines, *satvika* (pious, boiled) foods, the consumption of the sun-dried rice or *nimalya* that is the *prasad* (the uneaten remains of the food offered to a god) of the god Juggernaut or Vishnu, the ingestion or application to the body of the five products of the cow (ghee, blood, urine, dung, milk), the recitation of mantras, the reading of scriptures, the singing of *kirtans* (musical prayers), the offering of food (*bhoga*) to gods and ancestors, the exorcism of invading spirits, animal sacrifice, self-abnegation and devotional pilgrimage, the use of talismans, rubdowns of turmeric, the feeding of Brahmans, *paduka* (medicinal use of flowers offered the Goddess and of the water used to wash her feet), ritual cleansings, yoga, breathing exercises, and a highly significant dose of optimism and faith.

Moreover, these various traditions of medicine are not viewed as inherently opposed. Most rural folk and healers in rural India share with each other the following kinds of beliefs: that some illnesses are caused by infections of the body, and many are not; that there are numerous pains and aches of the body for which hospital doctors have no biological account; that diarrhea and the painful feeling of being pierced by a needle can have many possible causes; that powerful "black magicians" can make one lose weight or disrupt

digestion and have the capacity to paralyze, to make one behave strangely and shamelessly, and may even be able to drive one mad; that urine, stool, semen, blood, and other fluids of the body can be diagnostic of some of the true causes of suffering, both biological and spiritual; that when the medicine of the allopath and the baidya (ayurvedic) do not work, one should consider going to a kalisi (medium of the goddess); that when neither the doctor at the hospital nor the goddess in the temple is able to effect a cure, something else must be going on; that the society of spirits exists and that spirits have the ability to trouble human beings; that demonic planets can influence the humors or dosas of the body; that to be envious of others or covetous is to automatically cast an evil eye; that the emotion of fear (and psychological weakness more generally) is the major prelude to harmful effects of the evil eye and spirit possession; that when fear is the cause of suffering, allopathic and homeopathic doctors can do nothing about it, but one may be cured with talismans or by an exorcism; that some children are fearless and thus have a natural immunity to evil eye; that there is a difference between a case of mental illness and a case of spirit possession; that if you get no results from exorcism then evil eye is not at work; that ritual purity and righteous behavior protect from sorcery and disease; that some illnesses are cured quickly with allopathic medicines and that ayurvedic remedies are more gentle and gradual and take a longer time; that quacks, charlatans, pretenders, fakes, and incompetents exist within every tradition of healing; that protective devices such as talismans may be rendered useless by pollutions emanating from death, birth, and menstrual blood; that there is an appropriate food for every occasion and an appropriate substance to ingest for almost any difficulty; that the body is made of the five basic elements, in particular air, water, fire, earth, and ether; that there are six chakras and ten *indriyas* (gates or openings to the body, for example, the two eyes, the two ears, the anus, the genitals); that too much sex is bad for health and especially so on *sankranti* day (new moon day) and *ekadasi* day (11th day of the new moon cycle); that many aspects of fate are written on one's forehead in the first few days after birth as just dessert for virtuous and vicious actions in previous lives; that old sins and spiritual debts cast long shadows and, thus, ultimately the past catches up, even across rebirths; and that when it comes to understanding the complex causal forces and interactions of the human, spiritual, and divine worlds as related to any particular instance of illness and suffering, mere mortals are bound to be as ignorant as they are knowledgeable.

Because such ideas and understandings (meanings) are widely shared in rural India it should come as no surprise that after diagnosing symptoms a doctor in the local hospital may send a patient to a kalisi (the medium of the Goddess at the local temple); or that after reading someone's signs the kalisi may recommend a *devi sadhak* (someone capable of doing battle with the evil spirit sent by a powerful sorcerer), or an eye doctor.

Thus, one lesson I have learned in India is that it makes more sense to speak of traditions of medicine rather than of traditional medicine, while recognizing that every tradition, including Western allopathic medicine is an historical entity that has its own antique and contemporary forms. No tradition of medicine is uniquely modern. When someone asks about "traditional medicine," the most appropriate reply is "which tradition of medicine?"

Or put the other way around: Of the many traditions of medicine, why should we say that only this one or that one is "traditional"?

In the remainder of this article, I attempt to quickly canvas the broad domain called "health" and to elucidate some of the many traditions of medicine that exist and persist on a world-wide scale, and in India as well. As far as I can tell, almost every mode of medical thought and practice that has ever existed anywhere in the world (from Plato's ideas about reincarnating souls to Galen's biological theory of the humors of the body) has either been independently invented in India or has migrated to the subcontinent and flourished there, continuing to be carried forward and advanced by some tradition of healing or another. I want to suggest that there are many traditions of medicine precisely because there is something "essentially contestable" about the very idea of health and about the orders of reality that might plausibly be invoked in any particular explanation of suffering.

The Many Meanings of Health in One City in the United States

The most common way to conduct research on health in the United States is not through a physical examination or through the analysis of blood and urine or other juices, fibers or organs of the body. The most common way is through survey research in which respondents are asked questions, and the most common question asked is this one: "How would you rate your overall health (excellent, very good, good, fair, poor)?"

No one is quite sure what that question means, although people who say they are in poor health seem to die sooner than people who say they are in excellent health and the answer to the question predicts mortality somewhat better than lab results and a physical examination by a doctor (DeSalvo et al. 2005; Idler and Benyamini 1997).

Some years ago I conducted a graduate seminar at the University of Chicago on "Culture and Health" in which we attempted to determine what images and meanings members of seven different ethnic groups in the city of Chicago associate with the English word *health* when they are asked to answer that apparently straightforward, simple and surprisingly predictive survey probe. The members of the seminar conducted in-depth interviews with a small convenience sample of Polish Americans, African Americans, German Americans, Hispanics, Haitians, Japanese Americans, and Chinese Americans. Among other things, we asked informants to answer the question "How would you rate your overall health (excellent, very good, good, fair, poor)?" We then asked them to tell us what they thought we meant by the word *health* when we asked the question.

The results of this collective seminar project have been described in a manuscript by Joseph and Shweder (n.d.). What we discovered is that the English word *health* used in the standard survey probe is not unitary in its meaning and indexes a wide variety of intuitions, images, and implications about personal well-being that I briefly recapitulate and enumerate here.

- (1) Health as energy, energy reserve or energy potential. The basic idea here is that illness is the loss of energy reserve or potentiality. When that happens, as one informant put it, “you make a fast step to the bottom.”
- (2) Health as absence of unpleasant symptoms, including aches, pain, fever, etc. The basic idea is that one is healthy whenever biological functioning of the body does not intrude into consciousness, or as one informant put it, “nothing hurts and nothing itches.”
- (3) Health as the ability to carry on functions, duties, and activities of everyday life. The basic idea is that illness is the disruption of the capacity to perform daily routines or, as one informant put it, to be healthy is “being able to get around and enjoy yourself.”

There is one noteworthy variation on this “functional” idea of health, which might be classified as follows:

- (3a) Health is autonomy. The basic idea is that health means being able to function without a dependence on drugs, technologies, special assistants, or anyone else. If one requires eyeglasses to see, they are less healthy. If one has to use insulin to keep blood sugar levels under control, they are less healthy. If one needs to have children live nearby to keep from feeling sad and lonely, they are less healthy, and so forth.
- (4) Health as an objective physical fitness standard. For some informants health meant being able to engage in strenuous exercise. They might rate their health on the basis of the number of miles they could run each day. Health might mean ten miles a day. For others, especially for some of the women in our sample, weight and waist line were significant aspects of their conception of well-being. The basic idea being that one falls short of being healthy if they cannot live up to some objective standard (running 10 miles a day, having the right weight and waistline) which defines being physically fit.

One fascinating variant on this physical fitness standard idea of health that is now taking hold in the United States, perhaps under the dual influence of insurance companies and epidemiological researchers, is the following:

- (4a) Health is the absence of statistical risk factors. The basic idea here is that one is unhealthy or sick not because of actually suffering or experiencing symptoms of disease, but because of having risk factors (being overweight, smoking cigarettes, lack of physical exercise, fatty diet) statistically associated with suffering in the general population. According to this idea of health, one does not have to suffer or have any symptoms to be perceived as sick; one just has to be difficult to insure. In the minds of some Americans, the risk factors associated with illness have become the illness or the disease.
- (5) Health as diet or food. The basic idea is that the nature of substances ingested is the cause, expression, and indicator of overall well-being. One keeps oneself and family healthy by eating the right foods. “You are what you eat,” according to this view of health.

- (6) Health is the hardiness or the purity of one's inherited stock. The basic idea here is that to be healthy is to be able to resist and not succumb to bad or evil forces in the world (germs, viruses, etc.). One's capacity to flourish in the face of the dark forces of suffering can be traced to either good genes, a powerful immunological system, or some other ennobling characteristic of biological heritage.
- (7) Health is freedom from disease. The basic idea here is that health is a state of purity characterizing the body, mind, and the immediate social and physical world. Sickness is a state of contamination or pollution of psyche, soma, and environment by the destructive forces (germs, negative emotions, bad thoughts) that might make one suffer.
- (8) Health is a fragile equilibrium, a balance among diseases. Some people think of the human body as inherently diseased, bustling with germs, packed with toxins and highly vulnerable to suffering. From this point of view health is a fragile state of well-being experienced when different diseases, germs, toxins, and other nasty things floating around in one's veins counter balance each other in a state of equipoise. This physical equilibrium can be easily disrupted. Sickness is produced by loss of either balance or mental serenity, for example, as a result of fear, surprise, or traumatic shock.
- (9) Health is the control and management of emotions. The basic idea here is that illness, especially mental illness, is the loss of emotional control and self-regulation. Healthy people know how to interact normally in a dignified way with others in core social situations. It is tempting to wonder whether this image of health has some special relevance in the context of South Asian family life, where having no sense of "shame" (*lajya*) is sometimes associated with sickness and where a well-managed sense of respectful restraint (not "shyness" but, rather, sensitivity to the station and prerogatives of others) is thought to be both a constituent and a marker of personal well-being (Menon and Shweder 1994, 2003; Shweder 2003a).

It is not hard to imagine how each of these nine (plus two) intuitions about health might become the "root concept" for some elaborated school of medical thought. It is also not hard to imagine how each of these intuitions might already be partly informed by some well-worked out tradition of medicine (e.g., the concept of "energy" or *chi* in Chinese acupuncture) that has had an influence on popular culture in the United States. My only point in enumerating the different ways in which the abstract idea of health can be defined and given character is to suggest that the domain of health is sufficiently complex to support many traditions of medicine, without any one of them claiming special privilege.

The Many Traditions of Medicine: Which Is Traditional?

Not only is the very idea of health "essentially contestable" but so too are the orders of reality that might be invoked to explain why someone suffers. To suffer is to experience a disvalued and unwanted state of mind, body, or spirit. In an article by Shweder and colleagues (1997) we survey explanations of illness and therapeutic practices reported by

anthropologists on a world-wide scale and summarize some of the “causal ontologies” or orders of reality held responsible for suffering by indigenous folk and healers around the world. We introduce the idea of a “big three” set of explanations for suffering. I briefly recapitulate here.

“Everywhere in the world people believe in spirits; it is only in India that we treat the body with Mantras.” That remark, made by a local Oriya astrologer or *Ojha*, is essentially correct. There are certain very broad traditions of medicine (and associated causal ontologies of suffering and therapeutic practices) that are widespread around the world and other traditions of medicine that seem far more restricted in their appeal. The big three traditions of medicine are as follows (Shweder et al. 1997).

There is the biomedical tradition of medicine. The causal ontology of this tradition is notable for explanatory reference to fluids, juices, fibers, and organs of the body. Therapeutic practices of this tradition focus on ingestion of special substances (roots and shoots, chemical compounds, vegetable compounds, hormones, vitamins) and on direct or indirect repair or removal of damaged fibers or organs (e.g., via surgery).

The biomedical tradition of medicine is, of course, not peculiar to Western medicine, although critics of biomedicine in the West sometimes suggest as much. Humoral classifications of suffering, for example, are well within this biomedical tradition and are found all over the world. Humoral classifications group symptoms into kinds on the basis of presumed psychobiological or somatic causal links to a particular fluid of a particular internal organ. It is not hard to understand how organs and fluids can serve this taxonomic function or why such biomedical thinking is appealing. For example, normal versus abnormal conditions of the liver (a cool liver, a splitting liver) can be used as a way of making reference to, classifying, and explaining positive (purified) versus negative (poisonous) somatic and affective feeling states. They can serve this function because of certain ideas people have about the role of the liver, for example, that it removes toxins from the blood and is a catchment for poisons. Humoral theorists in many parts of the world have spent a lot of creative energy mapping liver malfunctions and the envisioned release of toxins into one’s system onto various symptomatic nonemotional feeling states (e.g., an itchy skin rash).

Humoral thinking is so widespread that even among enlightenment modernists in the United States, who have long since officially rejected this way of thinking about human suffering, it is almost commonplace to associate emotions such as anger, fear, love, sympathy, envy, and sadness with conditions of the blood, a humor of the heart. All the following meanings are well-entrenched in American English. The blood boils = anger. The blood curdles = fear. The blood flows freely because the heart pounds or because the heart breaks = love. The blood gets tired or ceases to flow because the heart is heavy or because there is a stone resting on the heart = sadness. There is no responsive blood flow because one is hardhearted or has a heart of stone = lacking in feeling and sympathy. Because of a lack of responsive blood flow one has turned “green” = envy.

Of course, not all biomedical explanations of suffering are the same. In the current mainstream Western variant of the biomedical tradition, the explanatory reference is to genetic defects, hormone imbalances, organ pathologies, and physiological impairments. In the current mainstream Hindu Ayurvedic variant of the biomedical tradition, the explanatory reference is to the dosas of the body and to other constituent elements. Nevertheless it is not difficult to recognize a certain deep kinship between geneticists, biochemists, and brain scientists at NIH and researchers at Ayurvedic Institutes in India. The particular fluids, juices, fibers, and organs to which they attend may differ yet from a broader biomedical perspective their discourses are but two currents in the same river of "fibers and juices" explanation.

The second of the big three traditions of medicine is the interpersonal tradition. The causal ontology of this tradition is notable for its references to sorcery, bewitchment, evil eye, black magic, spirit attack, and to potions and poisons used to control others. This tradition of explanation is associated with the idea that one can be made sick by the envy or ill-will of relatives, neighbors, schoolmates, and colleagues who want the victim to die, suffer, fail, or fall under their influence. The therapeutic practices of this medical tradition focus on protective devices such as talismans, strategies for aggressive counterattack such as countersorcery and, crucially and, perhaps most importantly, on the repair of "normal" interpersonal relationships. The interpersonal tradition of medicine is found almost everywhere in the world and is well-developed in India.

One example of an application of interpersonal medicine in rural India occurs in the context of the difficulties that sometimes arise during the female life stage known as *jouvana* (beginning when a woman gets married, typically between ages 18–25, and ending when she becomes manager of the household and enters the life stage of *prauda* [mature adulthood], typically in her early to mid-thirties; on women's life stages in Orissa, India, see Menon and Shweder 1998). Customary morality in rural India encourages arranged marriage and joint family living in the extended household of the parents of the groom. At the time of marriage, a woman shifts her kinship affiliation and is adopted into the lineage of her husband. A newly wed bride enters into a special status widely recognized in Hindu society as a temporary but difficult and vulnerable period of life. During *jouvana* there is a major loss of autonomy, power, control, and social support. There is the pressure and responsibility to have children and at least one male offspring. From the time she is married until the next stage of life when a woman assumes the role of household manager, a young woman in *jouvana* is more or less confined to her mother-in-law's house, where she devotes herself to doing service for many of the senior relatives in her new family (see Menon and Shweder 1998).

For many young, newly wed women in India, *jouvana* is a period of life when the respect, deference, and service they provide in the household of people who are initially strangers is rewarded by a sense of incorporation into a new kinship group and by the anticipation of the far more empowering life stage of *prauda* yet to come. I mention *jouvana*, however, because

it has been reported by some scholars of Hindu family life that this is a time when young women are especially prone to mental illness and to displays of listlessness, dissociative states, and other symptoms associated in the annals of Western psychiatry with “hysteria.”

An alternative interpretation widely available in rural India is that these women are not mentally ill but are, rather, momentarily possessed by a spirit and need to be exorcised. For example, as strange as this may seem to mental health researchers in the United States, in whose minds the society of the spirits and the society of gods do not exist and may even be viewed as delusional, the following story is well within the range of imagined possibility and rational discourse among many thoughtful people in rural, Hindu India.

There was a local Oriya man who captured two female spirits with his mantras and did all sorts of mischief with them. The spirits were named Malli and Champa. Everyone in the community knew that he had captured these spirits and kept them in his back courtyard where they protected his mango tree so no one could pick his fruit. What this man did was send his spirits to houses where newly married brides had arrived. The spirit went there and instantly the bride was possessed. It is a matter of “shame” to a family if a newly married bride gets possessed and acts as though she is senseless. So some of the family members would approach this man for a cure and he would remove the spirit and charge five rupees. Sometimes he would send the spirit a second time and then remove it again and the young woman would be cured. People hated him for sending spirits into their homes and they abused him when he died, but they needed him to make their daughters-in-law well. [This story excerpted from an interview during fieldwork in the 1980s, of course, presupposes the efficacy of exorcism, which is not an issue I address in this article. But before drawing any strong conclusions about exorcism it is well to remember what some historians of 16th- and 17th-century Europe pointed out, namely that no Protestant critic of Catholic exorcism ever complained that demonic possession was a chronic condition. In Europe back in those days, exorcism may have worked to cure Catholics of supposed spirit attack].

Is it possible to be possessed or confused by an invading spirit without being mentally ill? Is it possible for *paga* (“madness”) not to be a mental illness? I suspect most mental health researchers in the United States would say “don’t be ridiculous” or “of course not.” Most devout mental health researchers in the United States have a much less luxurious metaphysics than most devout Hindus in India. Most mental health researchers in the United States are prone to infer mental illness in cases where a young woman starts acting as though it is not a pretense and there is a spirit that has neutralized her will. A critical question that arises for cross-cultural communication and understanding, however, is whether it is possible for scholars who do not share the same metaphysics or picture of what is really real to agree on what the domain of mental illness encompasses or includes within its semantic range (or to even adequately translate each other’s terms for talking about “mental events”)?

I suspect that this is once again one of those areas where if we do not get beyond the illusion of shared meaning (she’s a “shy” girl) we may never learn what the “others” conception of the “mental,” “emotions,” and “mental and emotional health” is all about. The most

well-known Hindu theory of "basic emotions" (the phrase "basic emotions" is itself a hazardous translation of the Sanskrit term *rasa*), for example, is not closely aligned with ideas about "basic emotions" current in the psychological sciences in the United States (Shweder and Haidt 1999). It is not even clear that widely held American notions about "mind," "heart," and "body" (e.g., the idea that the mind is located in the head) map easily onto Hindu notions of "atma," "purusa," "bibek," "budhi," and "mana." Close attention to these issues is needed before we can be confident that we are speaking about the same things.

The third of the big three traditions of medicine is the moral tradition (see Shweder et al. 1997 for a detailed discussion of moral explanations of suffering, with special reference to the idea of karma; also see Brandt and Rozin 1997). The causal ontology of this tradition is notable for its references to transgressions of obligation, omissions of duty, and ethical failures of all kinds. The basic idea behind this moralistic approach to medicine is that suffering is the result of one's own actions and intentions, that outcomes (e.g., venereal disease) are proportionate to actions (e.g., sexual promiscuity), and that a loss of moral character is a prelude to misfortune and disaster. The therapeutic practices of this tradition focus on purification, confession, reparation, moral education, the adoption and continual maintenance of right practices, and the removal of accumulated spiritual debts by means of austere denials (e.g., fasting) and even self-mortification. The health behavior movement in the United States, with its emphasis on "clean living" and ascetic habits ("just say no" to fatty foods, cigarettes, alcohol, and premarital or extramarital sex) is well within this tradition of medicine.

I am not going to say much more about the moral tradition of medicine in India in this article, except to mention a few propositions that many Hindus consider obvious or self-evidently true. For example, that religion, family life practice and personal habits are closely interwoven, not separate domains (e.g., the kitchen is a holy place, the preparation of food is a sacramental event, the eating of food is an oblation, and who eats with whom in the family is regulated by rules of ritual purity). For example, that the maintenance of the purity of one's own body is a major aim in life, and a violation of customary behavior is a "pollution" that must be removed if one is to approach the God in the temple or even the God in your own home. For example, that religion (which includes customary practices and personal habits) is observed for better health.

Ablutions, oblations, pilgrimages, and acts of purification of all kinds, often performed after consultation with Brahmin priests and other experts on purity and pollution, are so significantly part and parcel of the Hindu way of life that it is easy to overlook the fact that they are highly refined applications of a moral tradition of medicine. As a result, Hindus are among the least fatalistic people I know. When things go wrong for the people I know in rural India, when they have difficulties in life, when they suffer pain and anxiety, they wonder about their spiritual debts and they believe there is always something they can do to empower themselves and improve their prospects for the future. The "Western" notion

that Hindus in the “East” are passive, lacking in a sense of agency or internal control and resigned to their fate, is one of the greatest of all cross-cultural misunderstandings.

Indeed, I want to conclude this article honoring Jerry Bruner and his original thinking about meaning making (and its implications for the cultural study of human psychologies) with a speculation about variations in the cultural psychology of moral responsibility, personal control, and agency. It seems to me noteworthy and revealing of the different intellectual tempers of certain subcultures in the United States and in India that when troubled Americans (in the relevant subculture) consult with a therapist to “recover memories” from early childhood they tend to recall themselves as victims and blame others for their current distress. What inferences are we to draw from the contrastive fact that when troubled Hindus in Orissa, India consult with a *poothi* (an oracle) to “recover information” about their earlier incarnated lives they invariably discover some fault of their own? First they are informed about some sin or transgression they committed in the distant past. Then they are given several prescriptions (make a sacrifice to the Goddess, ingest the five products of the cow) to offset their spiritual debts with some acts of virtue. In other words, they are empowered by their local metaphysical picture of the world to take charge of their life and they have a profound sense of personal efficacy as they strive to alleviate their suffering.

RICHARD A. SHWEDER is a Carnegie Scholar and William Claude Reavis Distinguished Service Professor in the Department of Comparative Human Development at the University of Chicago.

Notes

Acknowledgments. An earlier draft of this article, entitled “Traditional Medicine/Traditions of Medicine: The Meanings of Health on Two Sides of the Globe” was originally presented at the Indo–U.S.A. Workshop on “Traditional Medicine and Mental Health” hosted by the National Institute of Mental Health and Neuroscience (NIMHANS), Bangalore, Karnataka, India, October 13–17, 1996. My research in India over the years has been supported by the National Institute of Mental Health, the National Institute of Child Health and Human Development, and the John D. and Catherine T. MacArthur Foundation Health Program’s Research Network on Successful Midlife Development (MIDMAC). As a Carnegie Scholar (2002–04) I also wish to express my gratitude and thanks to the Carnegie Foundation of New York for their generous support of my research and writing.

1. I invite the reader to imagine that the authorial “voice” in this article is designed for a multicultural “Indo–U.S.A.” audience and is meant to invite joint reflection on the metaphysical assumptions that support any culturally constructed sense of what is really real.

References Cited

Brandt, Allan, and Paul Rozin, eds.
1997 *Morality and Health*. New York: Routledge.

- Bruner, Jerome S.
 1986 *Actual Minds, Possible Worlds*. Cambridge, MA: Harvard University Press.
 1990 *Acts of Meaning*. Cambridge, MA: Harvard University Press.
 1993 Do We "Acquire" Culture or Vice Versa: Reply to M. Tomasello, A. C. Kruger, and H. H. Ratner. *Cultural Learning: Behavioral and Brain Sciences* 163(3): 515–516.
- DeSalvo, Karen B., Vincent S. Fan, Mary B. McDonnell, and Stephen D. Fihn
 2005 Predicting Mortality and Health Care Utilization with a Single Question Health Services Research. 40(4 August): 1234–1246.
- Idler, Ellen, and Benyamini Yael
 1997 Self-Rated Health and Mortality: A Review of Twenty-Seven Community Studies. *Journal of Health and Social Behavior* 38(1): 21–37.
- Joseph, Craig, and Richard A. Shweder
 N.d. *Cultural Models of Illness and Health: Proposals from Ethnographic Research*. Unpublished MS, Committee on Human Development, University of Chicago.
- Menon, Usha, and Richard A. Shweder
 1994 Kali's Tongue: Cultural Psychology and the Power of Shame in Orissa, India. *In Emotion and Culture*. Shinobu Kitayama, and Hazel R. Markus, eds. Pp. 241–281. Washington, DC: American Psychological Association.
 1998 The Return of the White Man's Burden: The Encounter Between the Moral Discourse of Anthropology and the Domestic Lives of Hindu Women. *In Welcome to Middle Age! (And Other Cultural Fictions)*. Richard A. Shweder, ed. Pp. 139–189. Chicago: University of Chicago Press.
 2003 *Dominating Kali: Hindu Family Values and Tantric Power*. *In Encountering Kali: in the Margins, at the Center, in the West*. Jeffrey J. Kripal and Rachel Fell McDermott, eds. Pp. 80–99. Los Angeles: University of California Press.
- Shweder, Richard A.
 1984 Anthropology's Romantic Rebellion Against the Enlightenment: Or, There Is More to Thinking Than Reason and Evidence. *In Culture Theory: Essays on Mind, Self and Emotion*. Richard A. Shweder and Robert A. LeVine, eds. Pp. 27–66. New York: Cambridge University Press.
 1991 *Thinking through Cultures: Expeditions in Cultural Psychology*. Cambridge, MA: Harvard University Press.
 1996 True Ethnography: The Lore, the Law and the Lure. *In Ethnography and Human Development: Context and Meaning in Social Inquiry*. Richard Jessor, Anne Colby, and Richard A. Shweder, eds. Pp. 15–52. Chicago: University of Chicago Press.
 2003a Toward a Deep Cultural Psychology of Shame. *Social Research* 70(4): 1109–1130.
 2003b *Why Do Men Barbecue?: Recipes for Cultural Psychology*. Cambridge, MA: Harvard University Press.
- Shweder, Richard A., and Jonathan Haidt
 1999 The Cultural Psychology of the Emotions: Ancient and New. *In Handbook of Emotions*. Michael Lewis and Jeannette M. Haviland-Jones, eds. Pp. 397–416. New York: Guilford.
- Shweder, Richard A., Manamohan Mahapatra, and Joan. G. Miller
 1990 Culture and Moral Development. *In Cultural Psychology: Essays on Comparative Human Development*. James Stigler, Richard A. Shweder, and Gilbert Herdt, eds. Pp. 130–204. New York: Cambridge University Press.
- Shweder, Richard A., Nancy C. Much, Manamohan M. Mahapatra, and Lawrence Park
 1997 The Big Three of Morality (Autonomy, Community, Divinity) and the Big Three Explanations of Suffering. *In Morality and Health*. Allan Brandt and Paul Rozin, eds. Pp. 119–172. New York: Routledge.