ABSTRACT OF PAPER

CREATING THE MYTH OF HEALTH

by Cheryl L. Logsdon

This paper addresses the topic of health and how health is subject to mythicizing. It examines the importance of human values in the creation of working health definitions. In addition, the importance of societal interaction and communication within the limits of these health definitions is studied.

Research on this subject reveals that although health is a real entity, its explanations and manifestations are shrouded in myth. Information obtained from works written by cultural anthropologists as well as philosophers provide a foundation upon which the perception of health is shown to be a myth. Finally, it is suggested that recognizing these points will help the individual gain autonomy and the health professional gain cultural sensitivity.

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Since ancient times, myths have been used as functional tools for society, simplifying complex psychological aspects of the human experience. The more complex, multidimensional or mysterious this aspect was, the more involved was the myth created. Over time and across cultures, the psychological needs of societies have been in perpetual flux, and in consequence, the tools required to cope need to be mutable as well. Ancient myths are dispersed and are remolded into the myths that function as aids for the societies of the present. Health, with all of its unsolved riddles and myriad facets, is one of these fascinating and enduring concepts of humanity that has been consistently subjected to mythicizing.

In order to truly understand and appreciate the concept of health we must explore what lies beyond our everyday experience. Would it really be so scary if there was no ONE true reality? In the concluding pages of Walden, Henry David Thoreau wrote,

> We are acquainted with a mere pellicle of the globe on which we live. Most have not delved six feet beneath the surface, nor leaped as many above it. We know not where we are. Beside, we are sound asleep nearly half our time. Yet we esteem ourselves wise, and have an established order on the surface. Truly, we are deep thinkers, we are ambitious spirits! (Walden 222).

By delving beneath the membranes protecting their realities, Thoreau suggests, individuals will acquaint themselves more fully with the inner workings of life. Myths have proven to be ideal membranes, surrounding entities that are mutable and that evade solid explanation. Myths make discussing these entities more comfortable - the entire community joins together in recognition of and in reaction to the same

underlying beliefs.

The primary intent of this discussion is to show that health, as constructed and experienced by society, is a myth. On an individual level, this awareness will increase the role of self-determination in the quest for health. On the professional level, it will lead to a more culturally sensitive, and therefore more effective, administration of health care. Classifying the perception of health as a myth will be approached in a step-wise and straightforward manner. Rather than defining "myth" in one fell swoop, it will be defined systematically. The following sections of this essay will be demarcated by a heading in the form of a definition. Each facet of the definition of "myth" will be followed by and compared to the parallel facet of "health". In the concluding section, the societal relevance of creating health myths will be investigated.

MYTH: a popular belief or tradition that has grown up around something; especially one embodying the ideals and institutions of a society...

-Webster's Dictionary

There exists a consistent universal assertion that health is indeed something worth attaining. Why has health consistently been striven towards across cultures and throughout history? At the time of the signing of the World Health Organization Constitution in 1946 the sixty-one countries involved had the ambition to promote world health because they felt that health was an important ingredient in creating world peace. This assertion does not seem strange when one considers that the leaders of these countries believed the health and happiness of its people as individuals was inextricably intertwined with the welfare of the country as a whole. For example, a memorandum submitted to the WHO by the country of France states, "there cannot be any material security, social security, or well-being for individuals or nations without health...the full responsibility of a free man can only be assumed by healthy

individuals...the spread of proper notions of hygiene among populations tends to improve the level of health and hence to increase their working power and raise their standard of living..." The oldest concern of political philosophy, societal order, is apparent in this statement from the United States: "international cooperation and joint action in the furtherance of all matters pertaining to health will raise the standards of living, will promote the freedom, the dignity, and the happiness of all peoples of the world" (Callahan 259).

Ancient societies also idealized health and order. The ancient Romans established colleges of priests dedicated to the worship of the mythological Roman goddess of health and these priests were the only humans who could ask the goddess to heal sick individuals. Most importantly, only these priests could ask for the health of the State, because the Roman Empire was metaphorically considered a large body, susceptible to the powers of Health (de Commelin 359). If the State can be compared to an organism then societal disorder can be compared to illness. This has been the line of reasoning used for centuries to follow and is still used frequently in modern times.

Homosexuality: undesirable societal characteristic or illness?

In his article 'Ideology and Etiology' H. Tristram Engelhardt, Jr., editor of The Journal of Medicine and Philosophy at the time, believes that the key concept uniting cultures and nations in this quest for health lies in the desire to attain autonomy. He states, "This should be the guiding thread in the coincidence of our prudential values: interest in preserving our state as free, rational agents" (Engelhardt 274). And thus, anything that hinders a person's ability to act freely and rationally, for example, aging, would be considered a disease. Of course, this definition must be under the influence of limitations founded upon what level of autonomy is expected in society; simply becoming older does not necessarily have to be equated with disease. Engelhardt states "In deciding what limits to set to such expectations, one chooses the actual norms to be

used in the value judgments which specify the boundaries between health and disease" (Engelhardt 274). Here two important concepts relevant to the topic of health are introduced: the idea of norms and the realm of value judgments.

The concept of normality is made incredibly complex by the simple question, 'What is normal?' Mathematically, normality is what occurs fifty to one hundred percent of the time. Thus, if a state of normal health is manifest in greater than half of the population then the remaining, lesser half of the population, could be categorized as 'abnormal' and therefore 'unhealthy'. In daily practice, one quickly comes to understand that sometimes, those persons who exhibit 'abnormal' characteristics are actually considered quite healthy and may even end up being highly rewarded in society. Men who are seven feet tall and who can play basketball end up being millionaires. Brilliant individuals earn great respect from their peers. Physically beautiful individuals and gifted musicians become 'rich and famous.' Obviously being in the minority does not always have a negative connotation. Likewise, being in the majority does not always mean that health is present - a majority of people may have tooth decay in any particular society, yet tooth decay obviously does not make for healthy teeth.

Michael S. Moore further elaborates upon the relative insignificance of such physiological norms in determining illness by presenting what he terms 'a contemporary thought experiment…'

> ...Imagine an individual possessed of a cubical stomach. This stomach, although abnormal in its physical structure, functions perfectly efficiently in digesting foods; it thus allows its owner as long a life as people with normal stomachs. Suppose further it causes him no discomfort and that it allows him to eat and drink the variety and quantity of foods available in his society. Despite the presence of an abnormal physical condition, no one would call this individual ill (Moore 295).

Moore continues this line of thought by asserting that this individual, although not physiologically 'normal', would not be considered 'ill' because such physiological indications only "at best" suggest that a person may be ill. He writes:

> There are presumably physical causes for our being in all kinds of states, such as being a thousand miles from Paris or for being alert or angry. *Whether* there are physical causes for such states, and if so, *whether* they are manifested by abnormal physical structures, is irrelevant to whether or not one is ill, alert, angry, or a thousand miles from Paris. Merely discovering a physical deviation in no way tells us that the person whose body it is that deviates is ill. Rather, properly to predicate illness of another we need to know such things as whether he is in pain, is incapacitated, or is dying (Moore 295).

If an individual feels that he is in a certain state he is truly experiencing that state, regardless of the cause. Likewise, 'health' represents a certain state, an entity that unquestionably exists. However, because both the individual and the society will attempt to describe this state, their descriptions will try to make sense out of observable phenomena in the world and must presuppose judgements about what is considered proper, or normal, functioning of a human being. What then dictates what is considered normal versus abnormal functioning?

The key to this discussion lies in the second concept mentioned above: value judgments made concerning the relevance and the context of normality. Health is consistently striven towards because individuals and groups of individuals place significance around departures from the norm. Being in an intense state of physical pain is not usually considered 'normal'; and, interestingly, this state of prolonged distress is not usually considered 'healthy'. It becomes clear that we learn to value different states of health with reference to how these states of health influence the way we function in society. Serious depression is not considered a diminished state of

health necessarily because less than fifty-percent of the population exhibits severe depression. It is, rather, that our society has learned that those people who exhibit this state are less likely to exhibit the positive values of self-confidence and successful relationships with peers. Callahan writes:

> In our culture at least (and in every other culture I have ever heard of) it is simply impossible, finally, to draw any sharp distinction between conceptions of the human good and what are accounted significant and negatively evaluated deviations from statistical norms...No individual and no society would (save for speculative scientific reasons only) have any interest whatever in the condition of human organs and bodies were it not for the obvious fact that those conditions can have an enormous impact on the whole of human life (Callahan 265).

A positive state of health cannot be separated from the human values that cause the state to be assessed positively. Health is not a norm or a standard, yet it is a genuine entity that exists in our minds as well as in our bodies. In an attempt to explain and understand this obscure entity, we encompass it with myths rooted in a system of ideologies and values.

MYTH: A story, a theme, an object, or a character regarded as embodying an aspect of a culture -American Heritage Dictionary

Across time and across cultures, values are not homogenous and thus the value placed upon departures from the norm fluctuates. This fact becomes self-evident when one investigates cultures more closely. When one thinks about culture one does not usually think first about the values of health or the frequency of diseases present within that culture. Rather, if one is asked to define what culture is, or, for example, "How would you describe the Spanish culture?" the response may include a comment on the unity in one language, the type of food eaten, and maybe some of their customs and

traditions. What comes to mind most frequently when one thinks about culture is perhaps the first and most broad manifestation of culture - the culture of a nation. More specifically in this national scale, culture is represented by a group of individuals, or a society, within that nation who have created what may be termed a "logical construct" of uniform trends and unique regularities of behavior (Kluckhohn 924). The history of that nation, the unique traditions of its people which have been passed down from generation to generation, the rhythms of everyday life such as the time and the type of food consumption, and even the underlying philosophies of how life should be lived are all considered significant components of what help comprise a nation's culture. Due to certain boundaries, geographical or linguistic, nations have developed different strategies to raise their families, educate their children, and run their governments; they have even developed different ways of communicating feelings, emotions, and basic needs.

In the midst of the United States involvement in the Korean War (1945-1953) and at the forefront of the civil rights movement (1954 NAACP formed; 1955 Rosa Parks) the American culture itself was beginning to question the concept of culture while at the same time it was redefining its own. It seems appropriate that around that same time period the researchers Kroeber and Kluckhohn (1952) attempted a definition of culture:

> Culture consists of patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may on the one hand, be considered as products of action, on the other as conditioning elements of further action (Kroeber and Kluckhohn 181).

Thus, it becomes clear that cultures exhibit their unique patterns of behavior and have specific traditions because they too take root in the values inherent in the people comprising that culture. Both the concept of health and the culture in which that concept of health exists have branched from the values that the specific group of people holds and thus may be considered "products of action."

It is when culture acts upon its individuals that the circle makes a full turn; every particular culture teaches its new members what should or should not be valued. Behind the tradition, symbols, and actions of a nation lie the values of the people as individuals. It is true that within a certain culture there exist a large variety of different types of individuals, each relating to their culture in varying levels of accordance or discordance. Individuals within a culture can by no means be considered homogenous; this belief has most likely lead to stereotypes and strained relations. The French are not all 'snobby', and not all Americans are loud and annoying. In lieu of these attached values present within each individual in each cultural system, the second facet of culture becomes apparent. This personalized culture is manifest in the "pattern regularities in abstracted elements of their behavior" (Kluckhohn 924). Grace De Laguna sums up this philosophy of internalized norms perfectly:

> It is as if the basic pattern of the culture must be reflected in the internal structure of each individual person; as if the individual were in some sense a microcosm and the culture to which he belongs a macrocosm. Each individual, like a Leibnizian Monad, 'reflects' the culture of his world from his own point of view and with varying degrees of clearness and confusion (De Laguna 379).

The matching of goals and values between an individual and his or her society, however, may be crucial to the communication required for maintaining a positive state of health. In a study conducted by Salmond et al., the effect of cultural dissonance

between the values of individuals and those of the greater society upon levels of health was assessed. Among high-status men who migrated from an atoll in the Pacific to the more westernized lifestyle found in the mainland of New Zealand, those who more closely adhered to their traditional values had a significantly lower blood pressure than those who acclimated themselves to the new culture by compromising these traditional values. The author concluded that the increased blood pressure was a result of the increased internal conflict experienced by the men who had altered their value system.

The often-cited study conducted by Marmot et al. may also be included here as evidence of the importance of adherence to cultural values. In a comparison of three groups of Japanese men living in Japan, Hawaii, or California, it was found that an increased rate of coronary heart disease was linked to a decrease in adherence to traditional values. The community living in California manifested both of these attributes.

Further immigration and migration research has led some researchers to conclude that the degree to which value systems are in accordance or discordance will have an effect upon how well individuals will adapt in a new society (Corin 287). Depending upon how firmly the values of individuals' native cultures are entrenched in their personalities, the tasks of value matching, compromising, or rejecting will be facilitated or impeded in the cognitive networks of a new society. The motivations that persuaded the individuals to enter into a new culture must also be considered. If they were forced for some reason, political or other, to enter into a new culture, a lack of self-determination may lead to a situation where they detest having a new cultural system shoved down their throats. On the other hand, if monetary or opportunity possibilities present themselves openly to potential migrants and they daily dream of entering into a new culture and of acclimating themselves to the rhythm of that culture, their chances of adjusting well psychologically and physically are increased.

Even the ability to learn a new language, if necessary, is intricately influenced by motivational components. If individuals need to learn a new language in order to gain the basic necessities of life or social integration, there is no question that they will strive daily to do so. This language includes the spoken language used to communicate commonly between individuals, as well as the words used to describe illness experiences. On a more metaphysical level, cultural language also includes body language and psycho-physiological expression. The rules of grammar and phonetics, which result in spoken phrases, parallel the rules of complex societal interactions dictating and resulting in health manifestations. Thus, cultural support is important in influencing the health of individuals, and this influence may be reciprocated and aided by the individuals themselves in an advantageous or a detrimental manner to health.

The question must be asked: what is the most significant facet of culture, the culture of a nation or the culture incorporated by the individual? The answer to this question may depend on the investigator's own culture. Littlewood noted that European anthropologists tend to focus upon the more social aspects of interactions within cultures such as kinship ties or other social institutions while investigators from North America tend more to focus upon culture as an interpretation attributed most significantly to individuals.

Over time, the vantage point from which culture is viewed has also shifted. Throughout the 1950's, 60's, and 70's anthropologists primarily visualized culture in the form of 'webs of significance' which serve as a conceptual framework for its members and help form the way its people view and experience the world. When this culture-specific view of the world was applied to the realm of health, a wealth of studies were produced which presented evidence that shared value orientations about the world result in shared illness beliefs. In recent years, anthropologists have

approached culture as a perpetual flux of communication and negotiation on both individual and societal levels. By conceptualizing health as a myth, the fine line between these two approaches disintegrates and a new assessment becomes apparent. Cultural health myths form shared illness concepts while helping dictate and solidifying levels of societal communication. Individuals can never be completely isolated from cultural interaction - gender roles, family structuring and dynamics, interpersonal communications, and sexual practices are all influenced by cultural values; and all are intricately related to the health of the individual.

MYTH: A collective fantasy -Larousse

When diseases or illnesses are at first diagnosed it is because certain symptoms fall into specific categories of identification, and they are known, usually from experience, to be the result of some disease manifestation. There exists a myriad of data describing how cultures have significantly different frequencies of disease and research even presents diseases that are found only in one particular culture. The Japanese may be more or less neurotic, Americans may be more or less extroverted; but, interestingly enough, much of the statistical data backing such assertions may be significantly influenced by other factors than disease frequencies. Modern anthropologists have begun to call into question the relativity of their own beliefs about health and culture and how these beliefs affect the way they observe the world (Crapanzano 1992). Zola states that it is "selectivity and attention which get people and their episodes into medical statistics, rather than to any true difference in the prevalence and incidence of a particular problem or disorder" (Helman 116). Thus, the numbers generated from comparing health statistics in different cultures may hinge upon what categories have been created to further classify healthy and unhealthy individuals.

In research conducted by O'Brien, discrepancies in health categorization and treatment were found which could not be directly related to the actual rate of manifestation of these diseases. In the study, twenty diagnostic categories and twenty prescription drugs were assessed using data from five different European countries; and several interesting results were found. For example, in the UK, neurosis was the diagnoses 5.1% of the time as compared to 4.1% in France, 3.2% in Italy and 1.7% in Spain. Also in the UK, the major types of drug prescribed (8.6%) were the tranquilizers, hypnotics and sedatives, compared to a prescription rate of 6.8% in France, 3.1% in Italy and 2.0% in Spain.

A further example of this phenomenon is exemplified in two case studies concerning the differences in psychiatric diagnosis between the United States and the United Kingdom. In the first study, conducted by Cooper et al., researchers attempted to discover why hospital admissions for the condition "manic-depressive psychosis" was ten times higher in the city of London then in New York City. In an attempt to identify if these differences were due to variable use of terms and concepts or to a true difference in the rate of psychosis prevalence, project psychiatrists reassessed 145 consecutive admissions using standardized criteria. Although differences in disorder prevalence did exist between the two cities, project psychiatrists found that the New York hospital psychiatrists diagnosed patients as manic-depressive significantly less frequently than either themselves or the London psychiatrists. In addition, schizophrenia was more frequently diagnosed in New York, while affective illnesses were more readily diagnosed in London.

Did these psychiatrists actually perceive their patients differently or did they just assign different categories to patients even though the symptoms and the behaviors of the patients may have been agreed upon? Katz et al. attempted to answer this question by reinvestigating the British and American psychiatrists. After showing them films of

interviews with the patients, the psychiatrists were asked to write down perceived symptoms and then were asked to make a diagnosis. Not only was different symptomatology perceived by the two groups of psychiatrists, but there was also a significant discrepancy in diagnosis. The British perceived the symptoms of "retardation" and "apathy" less and virtually no "paranoid projection" or "perceptual distortion" as compared to their American counterparts. Perceiving the symptoms of schizophrenia less frequently led the British to diagnose it less frequently. One of the patients was actually diagnosed as schizophrenic by one-third of the American psychiatrists and by none of the British. The researchers conclude: "ethnic background apparently influences choice of diagnosis and perception of symptomatology."

MYTH: traditional story of ostensibly historical events that serves to unfold part of the world view of a people or explain a practice, belief, or natural phenomenon
-Webster's Dictionary

Different schools of healing within cultures and across cultures have created their own unique ways to explain and to clarify the concepts of health and disease. For example, the tactic of modern Western medicine has been to describe 'health' in terms of the absence of 'disease' which has lead to a more objective and scientific classification of health. In contrast, describing 'disease' in terms of 'health' leads to a more encompassing view of individual health. This approach is one of the underlying philosophies behind the holistic health movement, which includes such Oriental therapies as acupuncture and Traditional Chinese Medicine. Both of these basic approaches to health have come under scrutiny for various reasons. Western Medicine has been accused of being too restrictive and impersonal; and holistic medicine has been accused of being too vague; its results cannot be consistently supported and

reconfirmed using the scientific method.

Although these definitions at first may seem helpful to their respective followers, for the purpose of concept clarification, they may be founded upon faulty reasoning. In his article "The Concepts of Health and Disease and Their Ethical Implications" John Ladd, a former chairman of the Committee on Philosophy and Medicine of the American Philosophical Association, shares his philosophy that these definitions are based upon the principle of reduction which has been used to simplify the complex concept of health. Reduction is based upon the premise that if terms are interdefinable then the term that is the less basic can be replaced by the term that is more basic, or more standard. Therefore, for those relying upon the definition of disease in terms of health, like the members of the holistic health movement, disease is the less basic term and may be eliminated or replaced by the term 'health', which then becomes all encompassing. In contrast, the reductionist definition that lies behind the philosophy of Western medicine, replaces health with disease as the more basic concept; and thus disease has the tendency to become all encompassing.

Ladd asserts that the terms "health" and "disease" are not interdefinable for many reasons and, therefore, the principle of reduction cannot be used. The terms are not interdefinable for reasons including grammatical differences and the degree to which each may become manifest. Grammatically the word "health" cannot become a plural "healths", but disease, on the other hand, may be transformed into many "diseases." This could be significant because it is only possible to describe, and thus conceptualize, one general state of "health." In the same sense, health is representative of a general condition rather than an episodic manifestation like disease. One would not likely be asked to name which part of one's body is healthy. In addition Ladd states that "health is a dispositional property (capacity or power), whereas disease is an actual occurent property...it (disease) may be said to be a closed concept as compared with the

concept of health, which...is an open concept" (Ladd 278).

The previously mentioned philosophies which Western medicine and holistic schools use to categorize health and disease, although perhaps based upon incongruent reasoning, represent just two ways of explaining the relationship between health and disease. For example, what if a particular group of people explains disease and health in terms of supernatural forces, the vengeance or the favor of spirits? Neither viruses nor exercising daily would hold a particular relevance in their construction of health. Engelhardt writes, "We impart certain presuppositions to our considerations of illness or states of demonic possession by virtue of how we relate those observations to particular frameworks of explanation," (Engelhardt 268). Kleinman (1980) elaborates further upon the idea, that the concept of disease hinges upon certain explanations and he terms these explanations 'explanatory models.' These models "offer explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sickness." Further, these explanatory models provide answers to, and explanations for, various aspects of the condition at hand including the etiology, the symptoms, what is happening to the body, and, especially, appropriate treatments (Helman 94).

These explanatory models may differ with respect to the 'professional' convictions the healer has about health as well as with respect to the 'lay' convictions of the patient. Kleinman distinguishes three different sectors of society which all have their own way of approaching, classifying, and treating illness and disease: the popular sector, the folk sector, and the professional sector. The popular sector manifests its awareness of illness by informal and familiar treatments of illness, either physiological or psychological. In both Western and non-western cultures, Kleinman estimates seventy to ninety percent of health care occurs in this sector. The first awareness of illness is most frequently felt by the individual as distress, dysfunction, or any other

alterations that the individual deems to be a departure from whatever normal is thought to be. Sometimes, however, a friend or a relative may also bring a changed state to the individual's attention. In either case, the individual may choose to administer self-medications such as extra vitamins or herbs if he or she feels that the problem can be self-treated. The next step in what Kleinman terms the 'hierarchy of resort' is actively to consult friends or relatives, most often women or people known to have had some experience with the particular 'potential' disease at hand. For example, hairstylists or bartenders are notoriously accessible for counseling and advice, while people such as retired nurses may provide reliable help concerning more physiologically related conditions. In all cases, communication is very informal and never involves an exchange of money. In the popular sector the roles performed may be easily reversed, causing the advice-giver to become the advice-receiver, while in the other sectors this role-exchanging cannot occur.

Most importantly, within this popular sector lies a particular and a unique way of perceiving illness and disease and what should or shouldn't be done to maintain health and to help prevent becoming ill. For example, parents may tell their children, 'Don't go to bed (or outside) with your head wet or you'll catch a cold!' There are also sayings concerning what is to be done once one does catch that cold, e.g., 'Feed a cold and starve a fever.' Even beliefs that specific foods are better suited to treat specific ailments may be upheld in a community. It is not a coincidence that a prescription of HOT chicken noodle soup for a cold has been passed down from generation to generation; some cultures have used this idea of treating 'hot' or 'cold' diseases with 'cold' or 'hot' foods, respectively, for centuries. In fact, Western doctors may actually have touted some of these remedies as legitimate scientific treatments for ailments in the early stages of medicine.

It quickly becomes obvious that the members of this popular sector may have created their own concept of medicine and may even have fabricated their own beliefs about the inner workings of the human body and would have acquired this information through various interactions with other individuals in society or from borrowing concepts from the other sectors of health care, the folk or the professional. In a comparative study conducted by Boyle, a very large difference was discovered between what patients thought about certain body structures and what the doctors knew to be a physiological fact. Out of 234 patients, 14.9% believed that the heart occupied the greater part of the thoracic cavity and 58.8% thought the abdomen was occupied entirely by the stomach. In another questionnaire requiring patients to name the location of specific organs, 14% of the responses were vague, and 58% were incorrect (Pearson and Dudley 1545-1546). It is not instinctual to know what the inside of the body looks like or exactly how each organ may function. Folklore, books and personal experience can all help give form to the 'lay conceptions' about the human body. These conceptions all attempt to unravel the mystery behind health and to explain it away.

Before continuing along this line of thought it is necessary to present the remaining two sectors of health care, the folk and the professional. The folk sector can include the sacred or the secular, or both, and may be represented by such personalities as midwives, herbalists, witch doctors, or shamans. The folk sector is predominant in non-western societies and is marked by the same informality and familiarity in language as in the popular sector. The folk healer often includes family and friends and allows them to play a very significant and intricate role in the healing process. For these and other reasons, the folk sector is perhaps the realm of healing that is the most culturally similar in beliefs and practices to that of the popular sector. Helman writes, "Because folk healers...articulate and reinforce the cultural values of the communities in

which they live, they have advantages over Western doctors, who are often separated from their patients by social class, economic position, gender, specialized education, and sometimes cultural background. In particular, these healers are better able to define and treat 'illness' - that is, the social, psychological and moral dimensions associated with ill health, as with other forms of misfortune. They also provide culturally familiar ways of explaining the causes and timing of ill-health and its relation to the social and supernatural worlds" (Helman 61-62). Thus, the folk sector too has created its own explanations for health and the appropriate ways to address it.

The professional sector of medicine must now be investigated more closely, particularly with reference to the established medicine of Western societies. In contrast to the more holistic aspect of health supported by folk healers and other 'unconventional' healers, the dualistic approach of Western, scientific medicine introduced by Rene Decartes (1596-1650 AD) has segued into a much more pragmatic view of health promotion. The separation of the body from the mind and spirit made the diagnosis of health and disease much easier to understand in terms of experimental data and empirical results. Since human values could not be clinically tested, they lost most of their importance in the doctor/patient relationship. The human body, its interrelation with microorganisms and diseases, and its response to direct physical trauma from the environment could, however, be investigated and proven.

With the discovery of the antibiotic penicillin in 1928 by Alexander Fleming and the antimicrobial Sulfanilamide in 1932 by Domagk, Western society became enchanted with the thought that there could be a pill to cure every ailment. From the 1930's onward, medical schools across the United States would set the standard for the future of health care in America. Young physicians learned how to approach patients mechanistically; they were taught how to diagnose and to treat diseases. According to Helman, those who practice modern scientific medicine form a 'healing subculture';

and the members of this subculture, beginning as medical students, undergo a sort of 'enculturation' (Helman 86). During this process, the young healers learn the rules that they are to follow and the roles that they are to play. Conceptual models are created which emphasize a medical perspective based upon scientific rationality, emphasis on objective, numerical measurement and physiochemical data, mind-body dualism, viewing diseases as entities; and, finally, emphasis is placed upon the individual patient rather that upon any influences the patient's family or social life may have upon the health of the individual (Gordon 19-56). In turn, the concept of what is 'normal' often becomes a normalcy based upon physiological data that falls into a specific numerical range. Blood and urine tests are the indicators of this new normality, not necessarily values.

MYTH: ...embodies the ideals of a segment of society

-Webster's Dictionary

As in the United States, for example, this ideology has become quite powerful. The Western medical system is actually only practiced in a relatively small part of the world; yet, in the areas where it is practiced, it dominates. Stacey criticizes the inequalities found in both the medical systems in the USA and the UK. He has pointed out that these dominant medical systems tend to reflect both the ideology and the prejudices found within the greater society, especially in relation to gender, social class, and ethnic background. Perhaps it has not been an accident that the majority of doctors have been white males who are better paid than either their female or non-white counterparts. Western biomedicine is upheld by law, its members enjoy certain privileges and are often respected for their intelligence and rewarded both monetarily and socially. Through institutionalization within hospital settings in particular, critics

think the medical profession has been able to gain the greatest amount of sway. Here, a new society is formed with its own hierarchy which separates 'sick' individuals even further, depending upon what exactly is wrong with them and places them in a specific ward under the supervision of certain specialists. Away from home, family and friends, patients "undergo a standardized ritual of 'depersonalization' and are converted into a numbered 'case' in a ward full of strangers" (Helman 69). By no coincidence, it is in the superstructure of the hospital where medicalization runs rampant; medical terms, the medical way of thinking, and the medical way of interacting has by necessity become the way of life for many health care professionals. Constant psychological stimulation and interaction with others who have been taught to think along exactly the same lines and who are joined in one common philosophy of health care can only result in psychological inbreeding where certain ideologies become further solidified and reinforced.

Creating the Myth

Each subsection of society, popular, folk and professional, adheres to a dominant set of values and from these values stem different psychological requirements. The layperson values remaining a functional member of society and therefore no longer wishes to be in a dysfunctional state. The shaman or folk healer values a holistic way of life with regard to healing and thus requires a healing model that recognizes all aspects of human life. Medical professionals value life, with an emphasis upon science. A medical model had to be created in order to perpetuate a

domineering scientific psychology. In each subsection of society, explanations were created to support the principal psychology. These explanations were necessary to create logical models intended to overcome the paradoxical nature of normality versus abnormality, life versus death, and health versus disease. Different cultures also exhibit this universal need to overcome contradiction, to bring order out of confusion. Myths fulfill this need. By creating a specific way of explaining contradiction, one is essentially creating a myth (Levi-Strauss 39-40). These myths present living story-lines that help the members of society interact in an appropriate manner.

Each society divides its members into categories and defines those categories by certain standards and specific roles, the young and the old, the lower or higher classes, man or woman, healer or patient; and each group is expected to fulfill those roles deemed appropriate to that specific category. Societies have also elevated certain individuals to a relatively high status in which they are given the right to make powerful decisions, decisions which allow them to classify and to label other members of that society as sick or well. For example, in Western societies, medical professionals entertain this status. In other societies this role may be acquired through family labeling or individual assessment. In either case, once a status of sickness is verified, an individual's condition is transformed into an entity entitling that individual to assume a new role in society, allowing for special privileges or for avoiding responsibility. Callahan furthers this concept by introducing what he terms the 'blameless sick role' (Callahan 263). Callahan suggests that since socially undesired deviations are increasingly being explained in medical terms, anyone exhibiting such a deviation would be considered 'sick.' In turn, this sick person becomes 'blameless' for responsibilities that are not fulfilled - responsibilities that are expected to be fulfilled by healthy and productive members of society.

If one goes to a healer thinking that perhaps something is wrong with his or her

body, and the healer verifies this assessment with 'Yes you are sick', then society is very likely to also agree that 'Yes, you are indeed sick; and therefore we do not expect you to perform as well at work, for example, until you are healthy again.' Often, such an occurrence is very legitimate because physically and psychologically, one cannot usually perform as well when one is vomiting every five minutes or is in so much pain one cannot move.

One must consider what purpose the sick role would serve for a society. One clue lies in the recognition that many other societal structures have also been created to integrate its individuals and to soothe discord. Most cultures create certain days or occasions when people are allowed to side step their 'normal' expectations or activities and perhaps openly vent their built-up frustrations. Such occasions include Mardi Gras or Halloween, when individuals are encouraged to adorn themselves in costumes, and excess is permitted. The occasion of the 21st birthday in the United States or the 18th or 19th birthday in Canada often provide a socially acceptable reason to drink to excess. Cultures also provide their members with certain 'special occasions' when they can excuse themselves from work and spend time with family members. (Such as Thanksgiving or Christmas.)

Unfortunately, individual sickness cannot be scheduled in such a timely manner. Instead, cultures present acceptable collective 'coping strategies' that replace the solidarity of the individual with a social quest for health. Appropriate times and means of expressing illness, governed by the traditions and the rules of a culture, can funnel health expression into appropriate channels. These strategies are called 'culture bound syndromes'. Syndromes are 'culture bound' because they only seem to manifest themselves in certain cultures and do not exist in others. There are 'exotic' examples of these syndromes by Western standards, such as koro and windigo; but other syndromes

hit closer to home, such as anorexia nervosa. The importance of these syndromes lies in the fact that they provide the members of a certain culture with acceptable means by which emotions or frustrations may be shared with that person's respective culture.

In his article "The Culture Bound Syndromes," Julian Leff presents further details. *Koro*, for example, is a syndrome almost exclusively found in Southeast Asia. For the sufferers, koro consists of the belief that one's genitals are being retracted into one's body, and this retraction and eventual disappearance is believed to lead to death. It is not uncommon for a victim suffering from koro to induce family members, who may alternate turns, to hold his genitalia in order to prevent this retraction. (Local myth asserts that spirits do not have genitals, and thus the link to death was made.) Although most frequently suffered by the men of the population, women too have fallen victim to koro; and the occurrence of koro has even been known to reach epidemic proportions. In another culture bound syndrome prevalent among the Native American tribes of the Cree, Ojibway and the Salteaux tribes, termed *windigo*, an intense fear of cannibalism manifests itself in the belief in a giant ice spirit. During winters that are often very harsh and frequently faced with a dwindling food supply, the windigo is believed to possess individuals, bewitch them, and then instill in them cannibalistic urges. Symptoms of windigo include a general disinterest in food, often supplemented by nausea. Anxiety will continue to grow within individuals and within the community as a whole; and if the individual's symptoms are not assuaged in a number of days, they may even ask to be killed. A culture bound syndrome more familiar to the American reader, found almost exclusively in the Western world, is anorexia nervosa. Although sometimes experienced by men, this syndrome is primarily manifest in women in their late-teens or early twenties. Despite their having an emaciated body as apparent to others in the society, women with this syndrome experience an intense fear of gaining weight. As a result of this intense fear, a general revulsion for food may lead to

starvation and eventually, death. It has been hypothesized that such activities are prominent because these women feel that they have to compare themselves constantly with ultra-slim super models and are constantly bombarded with the ideal of a slim figure.

In each culture-bound syndrome listed above, the symptoms are presented in a specific way to society and each society responds accordingly. In the case of koro, perhaps the individual has sexual issues that he or she wishes to confront, and such a wish is socially valued and validated by allowing the individual to express this wish openly in the form of a physiological complaint. Social support is mobilized around the victims, and in a sense they are culturally healed. Windigo provides a means by which anxieties about starvation can be openly recognized and confronted. The greater society is able to join together, however detrimental to individuals with the syndrome, and struggle toward a common desire of eradicating hunger urges that could lead to the destruction of many more lives. In the last scenario, the psychological instability of the anorexic individual also became manifest in physiological complaints. Societies are more comfortable 'dealing' with physical problems rather than with psychological ones because physical entities are more tangible and are easier to recognize. Thus, often the only way individuals can share their inner minds or bodies to the greater society is to express them to society in a way in which society understands.

In research conducted by Kleinman (1986), the many variables working together in health and illness join in a full circle. Noticing the prevalence of cases of neurasthenia as the most common diagnosis for neurotic cases in China and the relative absence of cases in the Western world, Kleinman attempted to determine if this syndrome was truly culture-bound or if it was due to the existence of different diagnostic labels. It is worth noting that the diagnosis of neurasthenia actually did exist in the Western world during the nineteenth century, and such labels as depression and

anxiety have replaced this diagnostic category. Kleinman came to the conclusion that both the social and the professional facets of health play a role in the creation of neurasthenia. Again, psychological entities became manifest physically and thus were presented by the individual to society in a socially acceptable and understood way. The health professionals read and labeled the symptoms in a way that coincided with explanatory models while at the same time endorsing the individual's beliefs about how illness should be presented.

Helman introduces the downside of this phenomenon by presenting what is called 'culturogenic stress' (Helman 256-257). This stress is precipitated through the values and beliefs of a culture that may disturb an individual's health. In a parallel to the well known placebo phenomenon where an increased state of health is the result of positive beliefs and attitudes, this culturogenic stress is more akin to the 'nocebo' phenomenon where negative beliefs on health end in a decreased state of health. Both windigo and anorexia nervosa could feasibly be included in this category. In some cultures, values and expectations manifest themselves differently in different members of the community. For example, cultural beliefs may provide protective health features to women while at the same time, those same features may cause aggravations in health for the men in that population. Research conducted upon matrilocal societies has concluded that such societies offer more security and health benefits to its female members than to its male members (Corin 287). In a study assessing the differences in hypertension between male and female members of an elderly Navajo population, Kunitz and Levy found that in the male members of the community, there was a distinct connection between a low rate of diagnosed hypertension after having lived off of the reservation for at least one year. Since the elderly Navajo women actually showed an

increase in hypertension associated with off-reservation living, the researchers concluded that Navajo culture is perhaps more beneficial for preserving the positive health of its female members. Likewise, a study conducted by Dressler found that the social support characterized by close kinship ties in a southern black community of the United States was more beneficial for its male members than its female members. Mental health symptoms were found to be less prevalent in the males because extended family ties provided a means by which stress could be beneficially mediated and reduced; whereas, for women, these extended familial ties caused increased stress due to the imposition of strict advice or difficult obligations.

Societal expression of health depends greatly upon negotiations and interactions between its members. If Sally were to present her sexual frustrations in the form of koro-like symptoms to her family doctor, trained in Western medicine, she would be labeled psychotic. If Joe knew nothing about yearly check-ups with his local practitioner or of prescription medications he may be looking to his local shaman for health advice and gathering roots instead. The health reality that Americans live in is not necessarily the reality of health experienced by their African, French or Japanese peers. Indeed, the rules and regulations of societal interactions learned in one culture are not necessarily the same rules learned by cultural neighbors.

By expressing the symptoms of an illness in a way recognized by the greater society, an individual moves one step closer to the social equilibrium between health and illness. One must be aware of the normal versus abnormal distinctions or the relevant categories of illness created and understood by that society. Illness labeling serves the purpose of setting victims apart from other individuals in society, distinguishes their actions as relevant to a particular category, and determines the appropriate societal reactions to that individual. Corin writes, " . . . access to social

support depends partly on a person's ability to adopt the culturally acceptable idiom of distress. Manifestations of distress are part of an ongoing negotiation with one's workplace, family and other local contexts; otherwise, they can entail rejection and exclusion" (Corin 295).

For example, the most widely understood idiom of distress in the United States employs the use of technical terms and complex biology. Making a sickness into a medical phenomenon somehow makes it more real; and no one has the ability to make a sickness more medical than a medical professional. In his article, "The Who Definition of Health", the co-founder and director of the Hastings Center at the time, Daniel Callahan, addresses this problem in detail. Callahan thinks the power of the established medical professionals, especially in Western societies, to label certain social or character manifestations as normal or abnormal, and therefore healthy or diseased, is extremely dangerous and is certainly not in the best interest of the community, especially since human values are frequently linked to defining who is, and who is not healthy or diseased. If human values are factors in medical labeling then, Callahan thinks, morality and every other aspect of social well being would eventually be included in categorically defining sick and healthy individuals. Indeed, in the recent past, morality has been included in the creation of health definitions. For example, homosexuality was considered a mental illness for many years, and homosexuals were labeled as sick, not only by the community because their activities seemed to vary notably from commonplace sexual preferences, but also, perhaps more significantly, because they were labeled as such by medical professionals. Callahan terms this progressive ability of medical professionals to apply human values directly to a medical category 'medicalization' and insists that by no means should medical professionals become the 'gatekeepers' for human happiness or controllers of socially deviant behavior (Callahan 263). Other authors have also attempted to explain the cause of

medicalization. Ladd suggests that the philosophy of reductionism, mentioned previously, is the culprit (Ladd 276).

Another very powerful medicalizing factor in Western societies that helps to place people legitimately into the sick role is genetics. An excellent example of this lies in the mentality which led to classifying alcoholism as a disease. American society has come to understand, and indeed has been educated to believe, that alcoholics cannot directly be blamed for their drinking problem because it is in their 'genes.' And with the 'discovery' of the actual genes predisposing people to alcoholic tendencies, the stigmatization of alcoholics as immoral and lacking in self-control has transformed into a more understanding and forgiving relationship between the greater society and the unfortunate victim of heredity. If the alcoholic cannot help his or her situation then how can he or she be blamed?

For the Western world in particular, this medicalization is aided and strengthened by several other factors, including the pharmaceutical industry and the portrayal of societal roles in advertisements (Helman 138-139). Advertisement, especially of pharmaceuticals, is perhaps the most innervating link between medical profession and society, because the images enter the most personal aspects of an individual's life. Stimson conducted a study concerning psychotropic drug advertisements in the United Kingdom in which he investigated a possible link between the high rate of psychotropic drug prescription among women (prescribed at roughly twice the rate as compared to men) and the way advertisements may affect this. In fact, Stimson found that images of women were pictured fifteen times more often than images of men, and, in these images, women were often shown in situations "which generated stress, anxiety and emotional problems." Images of women on the edge of emotional breakdowns were not uncommon, and the advertisements seemed to say "certain life events put people in a position where the prescription of a drug might be

appropriate." This sexist bias was confirmed once again in a study conducted by Robins et al. They found that men and women have the same 'global rate' of active disorders, but the means by which these disorders are presented depended upon gender. Women more frequently suffer from somatization disorders, obsessive-compulsive disorders, and major depressive episodes, while men more frequently manifest adversity in the form of alcohol abuse or antisocial personality.

After repeated indoctrination, coping drugs begin to seem more and more 'normal.' In a study on the 'normalization' of drugs in Western cultures, Jones found that eighty percent of the patients he interviewed considered heroin a drug, while only fifty percent thought of morphine or tranquilizers as drugs. Only one third of the people interviewed thought of aspirin as a drug. Drugs that are not considered to be 'hard' drugs are thought of as ways to help individuals meet certain societal expectations; these 'good' drugs help smooth the rough edges and are viewed as 'little helpers' that make people easier to live with and helps them perform daily chores. This drug orientation is wide-spread in Western societies and includes 'socially accepted' drugs such as alcohol and tobacco which help individuals along what has been called "the chemical road to success," (Warburton 309-319). Thus, by medicalizing them, Western societies present more or less socially acceptable ways to confront difficult life situations. It is more socially acceptable for a man to be publicly drunk and for a woman to cry in public - and these activities are even taught as acceptable gender-specific ways of expressing emotion.

Several authors suggest that this medicalization allows doctors to take over actual portions of people's lives, particularly in women. According to anthropologists, the medicalization of pregnancy and childbirth in Europe and the United States is markedly more dramatic than in other non-Western cultures where the 'birth culture' is different (Helman 145). This birth culture, clarified by Hahn and Muecke, "informs

members of a society about the nature of conception, the proper conditions of procreation and childbearing, the workings of pregnancy and labor, and the rules of pre- and postnatal behavior." It is considered normal that when a woman in the US becomes pregnant, one of the first things she should do is to go to the doctor. Everything must be checked-out to make sure the mother, as well as the fetus, are healthy and that the pregnancy is progressing normally. Most striking, however, is the trend that finds mothers giving birth more frequently in hospitals than ever before. According to Leavitt, in the 1880's women gave birth with the aid of female attendants such as midwives and relatives; and this occurred most frequently in the woman's home. In this familiar atmosphere, doctors/medical professionals were rarely called upon to aid; and when they were called upon to assist a birth, they were allowed little control over handling of the birth process. However, after this time, the power of doctors and their control over childbirth gradually increased and reached a climax during the 1930's, at which time the majority of women were beginning to have their children in hospitals. In the 1980's, approximately ninety-eight per cent of childbirth in the United States took place in the hospital setting. In this unfamiliar setting the new mother was evaluated and 'cared' for with the instruments of science and technology. Kitzinger elaborates further upon this idea of medicalizing the experience of motherhood: "In large centralized, hierarchical institutions existing outside and apart from the family there is a special likelihood of these rituals being used to reinforce the existing system and maintain the power structure" (Kitzinger 181).

It has been suggested that in the past, myths were created to solidify and to strengthen the power of the ruling class. In the sixteenth century, chroniclers reportedly established a family tree linking the dynasty of Charles IX to those of Venus or Heracles (de Commelin xiv). With the same efficacy, modern power-holders create the same melange of wonder and rhetoric in an attempt to awe. Doctors are not akin to

gods, nor are they kings. By using a vocabulary of medical and scientific terminology they present themselves as highly educated and in many cases, superior to others with whom they speak. Everything we experience is not of a medical nature and therefore we cannot expect medical science to answer all of our questions about life and alleviate all of our problems. We must seek to answer some of these questions ourselves in order to gain power over our health choices and experiences. Next time you start feeling a little abnormal and instinctually call for a doctor's appointment, think about which myths have already been dictated to you and which you may choose to create.

APPLYING THE KNOWLEDGE

It is wonderful that all of the cultural research aforementioned could be conducted and that the conclusions may have the effect of opening minds to a new appreciation for the complexities of health. With a new awareness for how instilled cultural myths can affect each level of health care, those practicing health care have the responsibility to use this knowledge to improve and promote the quality of life experienced by those for whom they care. Philosophizing about values, health, or culture is worthless if no one internalizes and acts upon the positive messages behind the words.

Various prejudices, conflicting values, different explanatory models, and unreconciled cultures all may combine to form an impossible wall hindering communication. In the space where the health care professional and the patient meet, be it either in a hospital, a private office, or in a small village hut, these two models of health will meet and may have many different fates. In all cases, however, the diagnoses made by the healer must make sense to the patient or patients and the treatment must be understood. A quote from a doctor doing research and practicing health care in an African community sums up this idea perfectly:

> In the science paradigm, data are objective; they are collected as 'facts' by observation and experiment; the geologist studies rocks and the data he obtains do not depend on the rocks being aware they are objects of study. The scientist decides what should be studied; the objects of his investigation are passive. If social studies were able to proceed in exactly the same way as geology, the people being studied would play no part in deciding what should be investigated, how the data should be interpreted, what should be done with the results. The scientists are powerful, the objects of their inquiries weak. But in social and medical studies, the balance of power shifts. A variety of people with different interests must be recognized... (Lewis 120).

An awareness of the many complexities lingering behind concepts of health can have an enormous bearing upon what types of health care decisions are made. The extreme importance of understanding such concepts becomes particularly crucial in the application of these concepts. The following case history, presented by Helman and researched by Mull and Mull, describes the problems encountered when health care workers tried to introduce Oral Rehydration Therapy, or ORT, in a small Pakastanian community. The therapy was introduced by health care providers as an inexpensive and safe way to combat the dehydration associated with diarrhea, which poses a major threat to infants and children in many developing countries worldwide. In these developing countries it has been estimated that in children less than five years old, thirty percent die as a consequence of diarrhea; and this results in as many as three to five million deaths annually (Mascie-Taylor 35).

CASE HISTORY: Oral rehydration therapy in Pakistan

> A recent study by Mull and Mull in rural Pakistan showed widespread ignorance or rejection of ORT by mothers despite the fact that the use of ORT has been promoted on a national level by the Pakistan Ministry of Health since 1983, packets of oral rehydration solution (ORS) are available free of charge through government health outlets, and more that 18 million packets of ORS are produced annually by Pakistan's own pharmaceutical industry. The researchers found that many of the mothers were ignorant of how the ORS should be used, and some of them saw the diarrhea - which was very common in that area - as a 'natural' and expected part of teething and growing up, and not as an illness. Some believed it was dangerous to try to stop the diarrhea, lest the trapped 'heat' within it spread to the brain and cause a fever. Others explained infant diarrhea as due to certain folk illness such as *nazar* (evil eye), *jinns* (malevolent spirits), or *sutt* (a sunken or 'fallen' fontanelle, said to cause difficulty in infant sucking), which should be treated with traditional remedies or by traditional healers without recourse to ORT. Some of these mothers did not connect the fallen fontanelle with severe dehydration, and tried to raise the fontanelle by applying sticky substances to the top of the infant's head, or by pushing up on the hard palate with a finger. Many mothers in the group saw diarrhea as a 'hot' illness which required a 'cold' form of treatment - such as a change in maternal diet, or giving certain foods and herbs to the infant - to restore

> the sick infant to a normal temperature. They classified most Western medicines, such as antibiotics and even vitamins, as also 'hot', and therefore inappropriate for a diarrhoeal child. A few mothers even rejected ORS (which contains salt) because they believed that salt 'was bad for diarrhea' (Helman 9).

Knowledge of local customs and beliefs can indeed shed light upon various health manifestations. For example, religious beliefs may compel believers to participate in activities that are dangerous for health and that may even have deadly consequences. Such was the case for the women and children in the Eastern Highlands of Papua New Guinea. At one time, almost ninety percent of deaths in adult women could be attributed to a disease the locals called 'kuru'. Initially, researchers thought that kuru, as manifest by a chronic progressive disease of the central nervous system, was a problem of genetics. However, scientists negated this initial hypothesis when monkeys inoculated with brain material from individuals dying of kuru developed the same type of brain lesions found in the humans (Gajdusek 1973). Kuru was simply a viral infection spread when these women ingested the contaminated tissue of their dead kinsmen in a ritualistic burial ceremony.

An awareness of the various environmental and community factors which help to make certain diseases more prevalent is also important. For example, the living conditions and the proximity and number of the people in the community may make it more or less likely that a certain disease will spread. Each microorganism requires the presence of specific conditions in order to spread, which include factors such as a minimal population size and the type of host. For example, Black suggests that the measles virus requires a minimum population because it only exists in its human host for about a two-week period and therefore must change hosts at least twenty-six times a year. Fenner suggested that in other viruses the same minimum population would be required when no animal reservoir was present. Therefore, in smaller populations such

health problems as lice and pinworms may more likely be found as well as microorganisms which use non-humans as their host (Polgar 1964). Contact with vector organisms is also greatly affected by such things as seasonal patterns and climate. For example, measles is more prevalent during dry seasons and colder months; yellow fever cannot become manifest if all of the mosquito larvae are washed away during summer rain showers (Mascie-Taylor 10). Thus, external factors such as the environment, the climate, and the types of life in that area can all play just as large a role in creating the health of a culture as can the internal forces of values and belief systems.

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