

9572601

Narrative and the Cultural Construction of Illness and Healing

Edited by
Cheryl Mattingly
and Linda C. Garro



UNIVERSITY OF CALIFORNIA PRESS
Berkeley · Los Angeles · London

RA
418
N234

NLFHSS17/162

For Bill and Robert

University of California Press
Berkeley and Los Angeles, California

University of California Press, Ltd.
London, England

© 2000 by the Regents of the University of California

Library of Congress Cataloging-in-Publication Data

Narrative and the cultural construction of illness
and healing / edited by Cheryl Mattingly and
Linda C. Garro.

P. cm.

Includes bibliographical references and index.

ISBN 978-0-520-21825-3

1. Social medicine.
 2. Medical anthropology.
 3. Discourse analysis, Narrative.
 4. Medicine and psychology.
- I. Mattingly, Cheryl. II. Garro, Linda C.

RA418 .N36 2000

306.4'61—dc21

00-031629

Manufactured in the United States of America

09 08

9 8 7 6 5

The paper used in this publication meets the minimum requirements of ANSI/NISO Z39.48-1992 (Permanence of Paper). © 1997

Cultural Knowledge as Resource in Illness Narratives

Remembering through Accounts of Illness

LINDA C. GARRO

The narrative accounts examined in this chapter situate the occurrence of illness within the context of a person's life, relating how the past is remembered in accounting for a present condition. While not all illness conditions lead to retrospective assessments, remembering the past often accompanies the search for meaning, explanation, and treatment occasioned by illness. In talking about illness, whether one's own or another's, individuals remember, drawing on their experiences and knowledge to link the past with present concerns and future possibilities. The approach taken here relates cognitive perspectives on memory to how cultural knowledge serves as a resource in guiding remembering about the past (see also Garro in press).

Consistent with cognitively oriented psychological theories about memory, remembering is best understood as typically reconstructive rather than simply reproductive (Bartlett 1932). Poised between past and future, remembering is an active, constructive process; "what we recall depends on what we now believe as well as on what we once stored" (Neisser 1988a:49). As persons talk about their experiences, past events are reconstructed in a manner congruent with current understandings; the present is explained with reference to the reconstructed past; and both are used to generate expectations about the future. In response to a disruptive life event like illness, the reconstruction of the past in accounting for an illness, and dealing with the illness in the present and future, are often closely connected.

A relatively new area of psychological inquiry with potential relevance to understanding how illness accounts are remembered and told is autobiographical memory (two edited collections, Rubin 1986 and 1996, provide a good introduction to this rapidly growing and diverse literature). Although more restricted operational definitions are often used in research, *autobiographical memory* can be broadly defined as "the capacity of individuals to recollect their lives" (Baddeley 1992:26). Some of the interest in autobiographical memory research reflects a trend within cognitive psychology to study the everyday uses of memory—"how people use their own past experiences in meeting the past and future . . . under natural conditions" (Neisser 1978:13). As memories are often recalled as stories, researchers from very diverse perspectives (contrast the introduction from Rubin 1996 with Singer and Salovey 1993) highlight the role of narrative in communicating the remembered past. Narrative accounts convey the effort to make sense of the past from the perspective of the present. In going beyond a recitation of what merely happened, these accounts point to meaningful connections among events and states of affairs.

While there are some notable exceptions, autobiographical memory research has tended to be oriented around issues involving the recall of discrete events in an individual's past and is often concerned with the question of accuracy (i.e., how well memories reflect past events). Accuracy of memory is an important and complex issue, of special relevance to legal testimony and survey research, but it may be of limited applicability to understanding remembering in many other real-world situations. Bartlett, who first talked of remembering in terms of reconstruction, claimed that in "a world of constantly changing environment, literal recall is extraordinarily unimportant" (1932:204). By treating autobiographical memory as primarily a record of the past, researchers have paid much less attention to how memory can serve as a resource in everyday life (cf. Robinson 1986:23). Consideration of remembering within the context of daily life leads to questions such as how remembering the past relates to what is done in the present or planning for the future (Neisser 1988b), how an understanding of the past helps individuals give meaning to their lives and the world (Bruner 1990), or how hearing the remembered accounts of others augments the listener's "fund of cultural knowledge with which to meet future illnesses" (Price 1987:315). And it is issues like these that are of interest here.

Culturally available knowledge about illness and its causation can also be seen as a resource that may guide the interpretation and recon-

struction of past experience.¹ The relationship between what is "known" and what is "remembered" is explored in this chapter using accounts of diabetes obtained during the course of fieldwork in an Anishinaabe community. While the accounts presented in later sections of this paper are more complex, a very simple example can be provided here. The understanding that diabetes can develop from eating too much sugar is widely shared and thus can be considered part of what is "known" about the condition (although, as will be discussed later, this is not the only "known" shared explanatory framework for diabetes). In contrast to this general knowing, an example of "remembering" comes from a woman who talked about eating a lot of candy bars during her first pregnancy and connects this with a subsequent diagnosis of diabetes. As this example shows, remembering conveyed through a narrative account is not separate from what is known. Rather, through remembering, culturally available knowledge becomes situated knowledge, connected to a particular person, context, and illness history. Narrative provides a window on the processes involved in relating individual experience to preexisting explanatory frameworks available within a cultural setting (cf. Cain 1991; Mathews, Lannin, and Mitchell 1994).

This comparison of what is known with what is remembered brings to mind the well-known theoretical distinction in cognitive psychology between semantic and episodic memory. At a general level, episodic memory is defined as "the recording and subsequent retrieval of memories of personal happenings and doings," while semantic memory can be characterized as "knowledge of the world that is independent of a person's identity and past" (Tulving 1983:9). Despite significant controversy within psychology about different "kinds" of memory and distinct memory systems, the episodic/semantic distinction is seen as having heuristic value, providing a useful way of classifying different types of knowledge (Mandler 1985; see also Neisser 1988c). Although there has been considerable discussion concerned with whether the constructs of autobiographical memory and episodic memory should be considered equivalent or if episodic memory encompasses more than autobiographical memory (a particularly cogent discussion can be found in Brewer 1996), my purpose in introducing these constructs is to show that the distinction made here between what is known and what is remembered is compatible with current cognitive theories. With reference to the semantic/episodic distinction, D'Andrade has stated that culture seems to have its greatest effect on semantic memory (1995:217). Much work in cognitive anthropology, from differing theoretical perspectives, has focused

on shared cultural knowledge, on representing aspects of the way the world is understood to be within particular cultural settings.

Although coming at somewhat similar issues from a different angle, Borofsky (1994) recently proposed a continuum between "knowledge" and "knowing." At the "knowledge" end of the continuum is "understanding that is definite and delineated" and that may be treated as specific "facts" (335). Within a cultural setting, Borofsky describes knowledge as relatively constant—across time, across informants, and across context. In contrast, "knowing" is understanding that is "more fluid and flexible in character"; "affirmations that tend to vary with varying contexts" (335). While Borofsky's complex essay warrants more discussion than space here permits, this knowledge/knowing continuum parallels the semantic/episodic distinction in pointing to general knowledge versus understandings as observed in specific contexts. In addition, the fluidity of "knowing" is consistent with the observation that the same individual may give different narrative accounts in different contexts (Lang 1990).

Remembering is reflexive and generative. It may be long after the occurrence of a past experience that it becomes meaningfully connected to a current illness through a reflexive assessment. Relating preexisting explanatory frameworks to personal experience is also a generative process, involving the linking of the remembered past to plausible interpretations within the framework of possibilities afforded by culture. While the cultural understandings often can be said to be shared, there may be considerable variability and flexibility in how they are instantiated in acts of remembering.

Reference to the framework of possibilities afforded by culture or to culturally available knowledge is intended to recognize that remembering may be shaped by sources of information that are not widely shared in a cultural setting. This may include what is acquired through culturally provided tools such as books and television. Understandings about illness and treatment, like other aspects of cultural knowledge, are socially distributed within a cultural setting (D'Andrade 1995). Interactions with others, perhaps particularly those who claim knowledge of illness and its treatment, may be cited as a source of validation for one's perspective, contributing to the credibility and persuasiveness of the account presented. In addition, such interactions may come to guide how an individual reconstructs the past. Kleinman's (1980) formulation of clinical interactions as transactions between explanatory models is clearly pertinent. Through such interactions, a person seeking care may

examples, would note connections between specific life circumstances and a given explanatory framework. Rather than embedding alternative, contradictory plots or explanations in their accounts, individuals would often demonstrate the compatibility of possible explanatory frameworks. This can be seen in the previously mentioned account from the woman who linked diabetes with eating too many candy bars during pregnancy. In addition to indicating that diabetes results from individual dietary choices like consuming too much sugar, she also pointed to broader societal changes, contrasting the healthy "wild" foodstuffs eaten in the old days with the unhealthy, contemporary, store-bought foods that had resulted in a dramatic increase in sickness, including diabetes, throughout the community.

While the approach taken here does not preclude the potential for "multiple readings" within the narratives, to adopt Good and Good's phrase (1994:835), attention is directed to remembering and how the personal past is conveyed through narrative. In the three accounts that follow, cultural understandings or what is "known" about illness and diabetes can be said to be generally shared and serve as resources in reconstructing the past, but resources that are variably drawn upon and linked to personal experience and history through "remembering."

DIABETES IN AN ANISHINAABE COMMUNITY

In this section I present a rather abbreviated synopsis of the research project (additional details, including more information about the community, are available in Garro 1995, 1996). The research site is an Anishinaabe reserve community located in Manitoba, Canada. Anishinaabe, and its plural, Anishinaabeg, are how people refer to themselves within the community, although Ojibway or Saulteaux may also be used when communicating in English with individuals from outside the community. While some children speak only English, it is a community where most adults still speak their own language, Anishinaabemowin, and prefer it in most social settings.

As in many other First Nations' communities across North America, there has been a relatively rapid increase in cases of maturity-onset diabetes occurring since World War II, an increase that was documented for the general area of my fieldwork site in publications that started to emerge around the mid-1980s (e.g., Young et al. 1985). When I first started fieldwork in 1984, I had no plans to do specific interviews on understandings for particular illnesses. But as I spoke with community

come into contact with an essentially new framework or a new application of an existing framework, with this new knowledge playing a constitutive role in the reorganization and interpretation of past experiences. A similar reframing process occurred in a number of the narrative accounts obtained from members of a support group for individuals with problems associated with the temporomandibular joint (the condition is commonly referred to simply as TMJ). As a consequence of patients' being given a diagnosis of TMJ and through their interactions with others, including treatment providers and support group members, narrative accounts came to be structured around a shared model for TMJ (Garro 1994). Because knowledge about TMJ is not generally shared in North American culture, the shared model expressed by members of this group cannot be considered shared cultural knowledge, but it is culturally available knowledge.

While cultural knowledge may guide remembering along certain lines, relating culturally available knowledge to a particular life context does not happen in a straightforward, deterministic manner (cf. Price 1987:330). A number of studies point to multiple, even conflicting, explanatory frameworks that can potentially be applied to individual illness cases. Farmer's (1994) portrayal of the emerging cultural model of AIDS within a Haitian village encompassed two disparate explanatory frameworks, either "naturally" (e.g., sexual contact with someone who "carries the germ") or "unnaturally" (with AIDS being willfully and maliciously "sent" by another person).² In an essay on understandings about illness in the same Anishinaabe community referred to earlier, I noted (Garro 1990:443) that some illnesses, especially those that do not respond to treatment or that are deemed "unusual" (suspicion may be sparked for a variety of reasons), raise etiological questions that may lead to "a constant entertaining of alternative explanations" with divergent, and at times highly significant, implications for appropriate treatment. Good and Good (1994) discuss "subjunctivizing tactics" in Turkish epilepsy narratives. Drawing on the available body of cultural knowledge, these narratives contained multiple perspectives suggesting alternative plots about the source and outcome of the illness, which justified continued care-seeking and sustained hope for the possibility of cure.

Within the Anishinaabe community, however, a diagnosis of diabetes does not raise critical etiological concerns of the kind described in the preceding paragraph. Indeed, many of those interviewed expressed similar understandings about diabetes and, as will be seen in the specific case

members, a recurring topic concerned diabetes and high blood pressure, and how these were "new" illnesses that had not been present in the community in the "old days" but now were so common that some said it seemed as if "everybody is diabetic." The emergence of diabetes and high blood pressure as important health problems has occurred over the same time period as the move toward an economy based on purchased foods.

In Anishinaabemowin, *diabetes* translates as "sweet sickness" or "sugar sickness." As the name suggests, diabetes is seen as linked to sugar and consuming a lot of sugar (through foods or alcohol) often came up in informal discussions of how someone could develop this illness. Diabetes was also often described as a "white man's sickness." An illness labeled as a white man's sickness is seen as occurring for the first time after Europeans came to North America (other illnesses commonly referred to with this label include measles, tuberculosis, chicken pox, cancer, and high blood pressure). Talk about diabetes may bring up strongly articulated contrasts between the healthy and fortifying foods obtained through Anishinaabe subsistence activities in the past and the comparatively unhealthy reliance on the store-bought foods of the Anishinaabe present. As mentioned previously, these two broad explanatory frameworks are not necessarily seen as contradictory and were often proffered by the same person.

To further explore how community members made sense of these "new" illnesses, I carried out interviews with individuals who had been diagnosed with either diabetes or high blood pressure. In both studies, two interview formats were used. The first consisted of a series of open-ended questions based on Kleinman's explanatory model interview format (Kleinman 1980). In the second, individuals were presented with a series of statements and asked whether each was true. These statements were based on comments made in earlier informal interviews with community members—many came out of discussions about diabetes or high blood pressure, others came out of discussions of other illnesses. Although this analysis will not be presented here, the responses to these statements were examined using cultural consensus analysis (Romney, Weller, and Batchelder 1986; for an analysis of the diabetes data, see Garro 1996). Overall, however, the interviews provided support for shared cultural understandings about diabetes and the two broad explanatory frameworks described earlier.

How an individual understands an illness reflects both personal experience with this and other illnesses and information obtained through

other sources, such as interaction with others. Diabetes, as well as individual experiences with this illness, are topics of conversation. Scattered throughout the interviews are observations attributed to other individuals, especially other persons who have been diagnosed with diabetes.

Information from the biomedically oriented health professionals who provide treatment and health education services is also important. Unlike in juvenile diabetes, where heredity is considered to be a significant contributor, concerns about weight are often implicated in maturity-onset diabetes. While there is some variability among health professionals (see Garro 1996), in the majority of cases the emphasis is on weight (and not specifically on sugar consumption) and on efforts to convince patients to make comprehensive lifestyle changes in diet and exercise in order to lose weight. Anishinaabe healers, when consulted, are typically asked for herb-based medicines, said to be effective in controlling diabetes. Anishinaabe healers are rarely contacted about possible alternative diagnoses after a physician's diagnosis of diabetes.

Given the interview context, a difficult issue to assess concerns the extent to which individuals feel obliged to provide certain kinds of narrative accounts, such as those judged to be compatible with the counsel of health care workers. An earlier essay (Garro 1995) discussed how individuals talked about diabetes both as a result of individual dietary choices, often attributing these ideas to physicians and other health professionals, and as a "white man's sickness" linked to environmental and societal changes (both were expressed in the woman's account described in the introductory section). The focus here, however, is not on representing typical accounts, nor on describing consensus and variation within the community, but rather on narrative as a reflexive, generative, and flexible mode of thinking.

"That's how someone used to eat in the past"

When I spoke with the fifty-eight-year-old woman I'll call Ellie Spence, she described herself as no longer having diabetes. But, as became clear while we talked, her experience with diabetes led to significant and ongoing changes in the way she and her family ate. Like the other individuals interviewed, Mrs. Spence had been contacted by a staff person from the local health center, who asked permission for me to speak with her about diabetes. The visit to her home was somewhat unusual because before introductions and explanations about the research were made, she launched into her account:

I'll say where somebody gets sugar diabetes is the food we eat. Nobody ate canned food before [pause]. It's the white man's fault. White people put too much chemicals in the food. Anishinaabeg never had sugar diabetes. Nobody ate canned meat before. What someone used to eat was salt pork, dried beans, and eggs. Other things were also eaten. People would plant their own gardens for the winter. Corn was planted, for they would eat it during the winter along with other foods. For example, soup was made. In the past, Anishinaabeg used to eat cow hocks, like the pork hocks they have today. That's how someone used to eat in the past.

Mrs. Spence continued by enumerating more of the foods people used to eat when she was a child, a time before diabetes was known in the community. She talked about foods that were gathered, about fishing and hunting, and described the different ways the foods were prepared by her mother. She concluded her introductory statement with the following:

This is why I think someone has sugar today because of the foods someone eats now. I also did quit eating the foods I used to eat before. I quit food or meat from the can. Another thing, canned milk was never used before—no canned milk in earlier days. Now I never use that milk. That canned milk.

Mrs. Spence became even more explicit later when commenting on her situation when she was diagnosed with diabetes:

What I think is because of the foods. I was working at [name of business located off the reserve] at the time. I never ate right. We always ate "Klik" or "Spork" [these refer to canned meat products], anything at all, so that is where I think it came from. I was always busy and I had no time to cook a proper meal.

In constructing this account, Mrs. Spence taps into the broader discourse about "white man's sickness." When talking about illness conditions as "white man's sicknesses," individuals often mentioned the chemicals sprayed on crops or used in processing foods, such as canned foods. Typically, such statements are not tied to an individual's personal history but are comments about the community history, which help to explain the relatively recent emergence of white man's sicknesses, like diabetes, and the substantial number of persons diagnosed with these illnesses. Most remarks about "white man's sickness" can be understood as "a making sense of the past as a kind of collective autobiography" (Connerton 1989:70). Connerton (1989:21) identifies two types of narrative contexts used to understand others, but which may also be applicable to understanding oneself:

We situate the agents' behaviour with reference to its place in their life history; and we situate that behaviour also with reference to its place in the his-

tory of the social settings to which they belong. The narrative of one life is part of an interconnecting set of narratives; it is embedded in the story of those groups from which individuals derive their identity.

Remarks about "white man's sickness," whether integrated into a personal story or not, are often affectively laden, linked as they are to the disruption and destruction of the Anishinaabe way of life, which has been ongoing since first contact with Europeans. Such comments clearly take a moral stand and implicitly condemn prevailing practices in contemporary society. They can also be viewed as expressions of resistance to the tendency of biomedically oriented practitioners to highlight individual responsibility for diabetes through making recommendations that patients lose weight, change their diet, and get more exercise (Garro 1995).

Mrs. Spence's account stands out as distinctive because this collective memory has become personal knowledge, grounded in the particulars of her own life history. But the link between eating canned foods and developing diabetes was only reflexively established a number of years after her initial diagnosis and only after other explanatory frameworks had been found wanting. Mrs. Spence originally ascribed her diabetes to eating sugar and then to drinking alcohol. But when eliminating these items from her diet led to no change in her diabetes, Mrs. Spence revisited other possible explanations for diabetes within the context of her own past.

The last time Mrs. Spence went for a checkup at the local health center, she was told she no longer has diabetes. She credits this improvement to her return to the foods she remembers eating while growing up. Mrs. Spence's diet is based on foods her mother used to prepare, she has replanted her vegetable garden, and she obtains wild meat and fish whenever possible. With few exceptions, she does not eat canned foods but justifies her family's consumption of some particular types of canned foods, such as tomatoes, by pointing out: "Tomatoes have been in cans for a long time. I remember my mother buying them in cans a long time ago." Mrs. Spence also justifies her continued use of sugar, a food item many people with diabetes say should be avoided, by using only the brown and maple sugars with which her mother cooked.

What is remembered in this narrative relates her past to present understandings and future plans. Mrs. Spence's actions are consistent with generally shared cultural understandings concerning diabetes, and they also fit her own personal experience. But it should also be noted that this is a relatively unique response, although there were others who talked

represents a plausible account of her diabetes, in other words a possible version, it did not capture the meaning of diabetes for Mrs. Green or her response to this illness.

Mrs. Green told how "all of sudden she had sugar diabetes," an occurrence she linked with preexisting high blood pressure, citing the doctor as the one who pointed to this connection. Mr. Green explained how her high blood pressure resulted from working too hard, and the subsequent failure to stop working so hard after developing high blood pressure resulted in diabetes. According to Mrs. Green, the symptoms she attributes to high blood pressure are now accompanied by other symptoms seen as resulting from high blood pressure. The emergence of diabetes is taken by the whole family as an indicator of her deteriorating condition.

This reconstructed narrative, which connects diabetes and high blood pressure, is a powerful one for the Green family and derives its motivational force primarily from cultural knowledge about high blood pressure (Garro 1988). But it was only after Mrs. Green was diagnosed with diabetes that changes occurred at the family level. Mrs. Green states that since the diabetes diagnosis "my kids don't let me do anything" by assuming all of the household chores and thus making it possible for her to take things easier and get more rest. This construction also strengthens Mrs. Green's claim that her teenage children shouldn't stay out late giving her a "hard time" because the "doctor told me not to worry so much." While there were other individuals with high blood pressure who later developed diabetes, the linking of the two conditions did not figure prominently in other narrative accounts, nor did it provide an arena for constructing a response to illness. Working too hard and worrying too much are explanatory frameworks closely tied to high blood pressure, but such issues do not typically arise in accounting for diabetes. Frequent references to the physician's comments provide validation for embedding diabetes within a preexisting explanatory framework associated with high blood pressure.

"That's because of those bombs they're testing"

Mrs. Brenda Stevenson provides a distinct, yet similar, narrative reconstruction, again based on shared cultural understandings about diabetes. Forty-nine years old at the time of the interview, Mrs. Stevenson had been taking diabetic medications for nine years. A few years before the interview, one of her legs had been amputated because of diabetic com-

about the health benefits associated with eating wild meat or having gardens.

"My kids don't let me do anything"

Although Mrs. Green was the person I came to interview, her husband joined in on our conversation. After I explained why I had come, Mr. and Mrs. Green started to list the individuals they knew, including family members, who had been diagnosed with diabetes. At the end, they commented that everybody seemed to be getting diabetes and that the "new food" was causing "a lot of sicknesses."

Like Mrs. Spence, Mr. and Mrs. Green also attribute diabetes to changes in diet occurring within the relatively recent past. But, unlike Mrs. Spence, and like most others in the community, this collective explanation for diabetes is not central to Mrs. Green's personal narrative. She explained: "Nobody knows which one, because you eat everything. You don't know which one causes it." While this attribution presages a bleak future for the whole community, it appears to have little motivational force in their lives (see Strauss 1992:3, D'Andrade 1992). Mrs. Spence is atypical; most of those who talked about changes in diet did not see truly feasible alternatives to what they were currently eating. Even though wild meat is widely perceived as more salubrious than meat bought in stores, agricultural spraying and other modern practices are often seen as contaminating all foods, including wild foods. The uncontaminated foods of the Anishinaabe past are simply not to be found in present-day circumstances.

Mrs. Green talked about other people who either did or did not have diabetes. She told of a friend who "doesn't eat sweets but yet she got it." Mr. Green pointed out that he was the one who put lots of sugar in his tea. So, Mrs. Green, who is not fond of sweet foods or drinks, dismisses sugar consumption as an explanation for her diabetes. Mrs. Green also commented that her husband drinks a lot but that he didn't have sugar diabetes. In initiating the discussion of these possible causes, sugar and drinking, Mrs. Green reveals her knowledge of the common explanatory frameworks. That others commonly explain diabetes by reference to histories of eating too many sweets or drinking is what Mrs. Green "knows" about diabetes, but in addition she "remembers" specific instances that do not fit these generally shared understandings.

It became clear as our discussion continued that while the positioning of Mrs. Green's history within the context of broader dietary changes

provide a rationale for responding to illness. Mrs. Stevenson told of how an infection had developed in her remaining foot and the physician warned that another amputation might be necessary. Barbara, in hopes of averting a second amputation, consulted an Anishinaabe healer to see if the problem was a result of diabetes or something else. For a presumed complication of diabetes, this was a quite unusual step. It was also an action taken completely on Barbara's personal initiative and without informing her mother. Typically, if Anishinaabe healers are consulted about cases of diabetes, it is only to request herbal preparations seen as effective against diabetes. But, with the threat of a second amputation, Mrs. Stevenson's case was also highly unusual, and this raised etiological concerns, at least for Barbara.

The healer explained that while Mrs. Stevenson did indeed have diabetes (a "white man's sickness"), there was another cause for the infected foot (an "Anishinaabe sickness"), broadly indicating that it was attributable to an inappropriate past action by Mrs. Stevenson (see Garro 1990 for further discussion of these issues). He asked Barbara to bring Mrs. Stevenson to see him and suggested that she would know why the infection had developed. For an illness of this type, remembering an appropriate past incident is an integral part of treatment. Being told what the healer said, Mrs. Stevenson did indeed remember a failure to keep a sacred promise she made when much younger, a pledge to dance in the annual Sun Dance for a three-year period. The pledge was broken when she did not participate during the third year. When visiting the healer, Mrs. Stevenson was advised how to make amends and was also provided with an herbal preparation for soaking her foot. Mrs. Stevenson and her daughter both acknowledged the healer's role in averting the amputation by providing a way of redressing the underlying problem. In this instance, the healer guided Mrs. Stevenson to consider a different illness condition with an alternative explanatory framework, but it was Mrs. Stevenson who reflexively evaluated the applicability of his advice within the context of her own life.

While "white man's sicknesses" and the contamination of contemporary foods came up in many of the interviews, in only a relatively few instances, including two of the narratives recounted here, is this collective reconstruction used to elucidate personal history (cf. Brodwin 1995; Lang 1990). This may be a reflection of the interview context. Still, nar-

82

Linda C. Garro

plications. Like Mrs. Green, Mrs. Stevenson raises some of the explanatory frameworks closely associated with diabetes only to reject them. Simply eating too many sweet foods cannot be the cause, because she knows someone who has diabetes but who never touched sweets or sugar. She also knows many people who are overweight but who don't have diabetes. It couldn't come from drinking, because she never drank, and anyway, if that were true, then there should be more diabetes "because everybody drinks." Mrs. Stevenson went on to buttress this argument with personal testimony, claiming: "Whatever the doctor told me, I tried it, but it didn't help me. I went worse. Now I just eat normal the way I eat." For example, the doctor told her not to eat too many sweets, but when she did this, it had no effect on her illness. On the contrary, she says she often feels better when she eats sweets. Mrs. Stevenson feels that there is little she can do in response to this illness, except to maintain her strength by eating well and normally and taking her prescribed medication, which she likens to vitamins because they "build you up" and help the body deal with poorer quality contemporary foodstuffs.

Although Mrs. Stevenson is dismissive of the advice she attributes to her own doctor, she referred back to a newsreel she watched years previously:

A long time ago there was a doctor . . . about thirty years ago, when we used to have those picture shows here. And that doctor told everything about how you are going to be, you're going to have sore bones, you're going to have headaches. That's because of those bombs they're testing, he said. That's going to settle down. You'll even get it from the milk, you'll get it from the crop. He told us everything in that news. That's why people are going to get weaker and weaker, he said. I believe that now.

Mrs. Stevenson remembers this newsreel as a portent of what later came to pass. Diabetes is but one of the consequences of the ongoing contamination of the environment and food supply by white men. Other events, like the Chernobyl nuclear disaster, were cited, and Mrs. Stevenson pointed to the ubiquity of chemicals throughout the food chain. Unlike those of Mrs. Spence and Mrs. Green, Mrs. Stevenson's personal history is irrelevant to understanding why she developed diabetes. It makes no sense to her to single out any particular foods because "you can get it from anywhere." For Mrs. Stevenson there is no escape.

On a visit to Mrs. Stevenson's home several months after the interview, I spoke with her and her daughter, Barbara, about a recent health problem of Mrs. Stevenson's. This conversation is detailed here because it illustrates how switching between interpretive frameworks helps to

CONCLUDING COMMENTS

While "white man's sicknesses" and the contamination of contemporary foods came up in many of the interviews, in only a relatively few instances, including two of the narratives recounted here, is this collective reconstruction used to elucidate personal history (cf. Brodwin 1995; Lang 1990). This may be a reflection of the interview context. Still, nar-

CONCLUDING COMMENTS

While "white man's sicknesses" and the contamination of contemporary foods came up in many of the interviews, in only a relatively few instances, including two of the narratives recounted here, is this collective reconstruction used to elucidate personal history (cf. Brodwin 1995; Lang 1990). This may be a reflection of the interview context. Still, nar-

ratives of this type serve to reinforce the connection between collective history and illness, helping to maintain this explanatory framework as a cultural resource for understanding individual illness experience as well as an explanation of why diabetes and other "white man's sicknesses" have emerged as significant health concerns in recent years.

These narratives also point to the wide range of possible explanatory frameworks in memory that can serve as additional resources when those more closely associated with an illness condition do not seem to fit a personal reconstructive context. One example of this can be seen in the situating of Mrs. Green's experience with diabetes within the shared cultural model for high blood pressure. Mrs. Green's report of the co-occurrence of symptoms ascribed to high blood pressure and those attributed to diabetes helps justify this connection. An instance of a more radical shift to an entirely distinct explanatory framework can be seen in the redefinition of Mrs. Stevenson's foot infection as an "Anishinaabe sickness" rather than as a complication resulting from diabetes. Further evidence that this is a significant departure from more conventional ways of talking about diabetes is that unlike, say, sugar or drinking, which were often advanced only to be dismissed as not relevant to an individual's story, "Anishinaabe sickness" was never put forward simply to reject it. Indeed, asking specifically about a connection between diabetes and Anishinaabe sickness was typically considered a quite humorous question.

Both Mrs. Green's and Mrs. Stevenson's accounts show how remembering can be guided by others, albeit in a selective fashion, and especially by those in healing roles. The physician and the Anishinaabe healer are both used to validate a particular narrative reconstruction. Mrs. Stevenson also couches her discussion of "white man's sickness" with reference to a physician on a newsreel and predictions of increased illness as a result of environmental contamination. In all three of these instances, these allusions to specialists can be seen as contributing to the credibility and hence the persuasiveness of the story. Still, it is only the broad narrative contour that is framed with reference to the specialist; the story is filled in and reconstructed within the context of individual lives, and it is this elaboration that contributes even more to the compelling quality of these accounts (see Pillemer 1992:244-45).

These three case examples illustrate how through "remembering" their experiences with diabetes, individuals variably draw upon culturally shared knowledge in constructing a narrative account. With reference to understandings about diabetes, the culturally available explana-

tory frameworks do not shape the construction of illness experience in a deterministic fashion but are flexible and provide relatively wide latitude for constructing a narrative that is both plausible and consistent with individual experience. Attending to the "known" and the "remembered" illuminates how culturally available knowledge serves as a resource in assigning meaning and in responding to illness.

NOTES

1. One form of representation widely accepted in cognitive science is the schema. Schemas are the underlying cognitive construct for the explanatory frameworks presented in this chapter. More formally, cognitive schemas can be defined as "learned internalized patterns of thought-feeling that mediate both the interpretation of on-going experience and the reconstruction of memories" (Strauss 1992:3; the phrase "thought-feeling" comes from Wikan 1989). Accordingly, cultural schemas or cultural models can be seen as those cognitive schemas that are generally shared in a particular setting. Cognitively oriented anthropologists have long been interested in how generally shared cultural schemas come to be constitutive of individual-level schemas.

2. Farmer's processual ethnography is also of interest because he claims that in the development of a cultural model for AIDS, illness stories of known individuals "provide the matrix within which nascent representations were anchored" (1994:801). Consensus in the meanings associated with AIDS emerged and became established through the generation and discussion of illness stories.

REFERENCES

- Baddeley, Alan D. 1992. What is autobiographical memory? In *Theoretical perspectives on autobiographical memory*, edited by M. A. Conway, D. C. Rubin, H. Spinnler, and W. A. Wagenaar, 13-29. Dordrecht: Kluwer.
- Bartlett, Frederic C. 1932. *Remembering: A study in experimental and social psychology*. Cambridge: Cambridge University Press.
- Borofsky, Robert. 1994. On the knowledge and knowing of cultural activities. In *Assessing cultural anthropology*, edited by R. Borofsky, 331-47. New York: McGraw-Hill.
- Brewer, William F. 1996. What is recollective memory? In *Remembering our past: Studies in autobiographical memory*, edited by D. C. Rubin, 19-66. Cambridge: Cambridge University Press.
- Brodwin, Paul E. 1995. Discussants' comments at a session entitled "Narrative as construct and as construction: Stories in a world of illness" (part 1). Ninety-third Annual Meeting of the American Anthropological Association, Washington, D.C., November.
- Bruner, Jerome. 1990. *Acts of meaning*. Cambridge, Mass.: Harvard University Press.

- edited by M. M. Gruneberg, P. E. Morris, and R. N. Sykes, 545-60. Chichester, England: Wiley.
- . 1988c. What is ordinary memory the memory of? In *Remembering reconsidered: Ecological and traditional approaches to the study of memory*, edited by U. Neisser and E. Winograd, 356-73. Cambridge: Cambridge University Press.
- Pillemer, David B. 1992. Remembering personal circumstances: A functional analysis. In *Affect and accuracy in recall: Studies of "flashbulb" memories*, edited by E. Winograd and U. Neisser, 236-64. Cambridge: Cambridge University Press.
- Price, Laurie. 1987. Ecuadorian illness stories: Cultural knowledge in natural discourse. In *Cultural models in language and thought*, edited by D. Holland and N. Quinn, 313-42. Cambridge: Cambridge University Press.
- Robinson, John A. 1986. Autobiographical memory: A historical prologue. In *Autobiographical memory*, edited by D. Rubin, 19-24. Cambridge: Cambridge University Press.
- Romney, A. Kimball, Susan C. Weller, and William H. Batchelder. 1986. Culture as consensus: A theory of culture and informant accuracy. *American Anthropologist* 88: 313-38.
- Rubin, David C., ed. 1986. *Autobiographical memory*. Cambridge: Cambridge University Press.
- , ed. 1996. *Remembering our past: Studies in autobiographical memory*. Cambridge: Cambridge University Press.
- Singer, Jefferson A., and Peter Salovey. 1993. *The remembered self: Emotion and memory in personality*. New York: Free Press.
- Strauss, Claudia. 1992. Models and motives. In *Human motives and cultural models*, edited by R. G. D'Andrade and C. Strauss, 1-20. Cambridge: Cambridge University Press.
- Tulving, Endel. 1983. *Elements of episodic memory*. Oxford: Oxford University Press.
- Wikkan, Unni. 1989. Managing the heart to brighten face and soul: Emotions in Balinese morality and health care. *American Ethnologist* 16: 294-312.
- Young, T. Kue, L. L. McIntyre, Joseph Dooley, and J. Rodriguez. 1985. Epidemiological features of diabetes mellitus among Indians in northwestern Ontario and northeastern Manitoba. *Canadian Medical Association Journal* 132: 793-97.

- Cain, Carole. 1991. Personal stories: Identity acquisition and self-understanding in Alcoholics Anonymous. *Ethos* 19: 210-53.
- Connerton, Paul. 1989. *How societies remember*. Cambridge: Cambridge University Press.
- D'Andrade, Roy G. 1992. Schemas and motivation. In *Human motives and cultural models*, edited by R. G. D'Andrade and C. Strauss, 23-44. Cambridge: Cambridge University Press.
- . 1995. *The development of cognitive anthropology*. Cambridge: Cambridge University Press.
- Farmer, Paul. 1994. AIDS-talk and the constitution of cultural models. *Social Science and Medicine* 38: 801-9.
- Garro, Linda C. 1988. Explaining high blood pressure: Variation in knowledge about illness. *American Ethnologist* 15: 98-119.
- . 1990. Continuity and change: The interpretation of illness in an Anishinaabe (Ojibway) community. *Culture, Medicine and Psychiatry* 14: 417-54.
- . 1994. Narrative representations of chronic illness experience: Cultural models of illness, mind and body in stories concerning the temporomandibular joint (TMJ). *Social Science and Medicine* 38: 775-88.
- . 1995. Individual or societal responsibility? Explanations of diabetes in an Anishinaabe (Ojibway) community. *Social Science and Medicine* 40: 37-46.
- . 1996. Intracultural variation in causal accounts of diabetes: A comparison of three Canadian Anishinaabe communities. *Culture, Medicine and Psychiatry* 20: 381-420.
- . In press. The remembered past in a culturally meaningful life: Remembering as cultural, social and cognitive process. In *The psychology of cultural experience*, edited by H. Mathews and C. Moore. Cambridge: Cambridge University Press.
- Good, Byron, and Mary-Jo DeVecchio Good. 1994. In the subjunctive mode: Epilepsy narratives in Turkey. *Social Science and Medicine* 38: 835-42.
- Kleinman, Arthur. 1980. *Patients and healers in the context of culture*. Berkeley and Los Angeles: University of California Press.
- Lang, Gretchen Chesley. 1990. "In their tellings": Ethnographic contexts and illness narratives. Paper presented at the Eighty-ninth Annual Meeting of the American Anthropological Association, New Orleans, November.
- Mandler, George. 1985. *Cognitive psychology: An essay in cognitive science*. Hillsdale, N.J.: Lawrence Erlbaum.
- Mathews, Holly F., Donald R. Lannin, and James C. Mitchell. 1994. Coming to terms with advanced breast cancer: Black women's narratives from eastern North Carolina. *Social Science and Medicine* 38: 789-800.
- Neisser, Ulric. 1978. Memory: What are the important questions? In *Practical aspects of memory*, edited by M. M. Gruneberg, P. E. Morris, and R. N. Sykes, 3-24. London: Academic Press.
- . 1988a. Five kinds of self-knowledge. *Philosophical Psychology* 1: 35-59.
- . 1988b. Time present and time past. In *Practical aspects of memory: Current research and issues*. Vol. 2, *Clinical and educational implications*,