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Bad Blood, Spoiled Milk

Bodily Fluids as Moral Barometers in Rural Haiti

(1988)

Current discourse in medical anthropology is marked by an increasing appreciation of the body as physical, social, and political artifact. Concepts such as somatization, which implies the making corporeal of nonbodily experience, are by now common coin, and there is considerable enthusiasm for the increasingly fine-grained analyses that appear in several new specialty journals. But others discern an overweening analytic urge that yields fragmentary knowledge resistant to synthesis. Illness experiences are picked apart under the dissecting gaze not only of biomedicine but of anthropology as well, a discipline long parsed into such officially sanctioned subfields as "psychological" and "biological" anthropologies. Appreciating the full weight of centuries of what has come to be called Cartesian dualism, Nancy Scheper-Hughes and Margaret Lock write forcefully of our "failure to conceptualize a 'mindful' causation of somatic states."[1] How might we gather up our fragmentary knowledge? Several of those seeking to reconcile the three bodies have turned, in the past few years, to emotion.

An illness widespread in rural Haiti speaks to this and several other dilemmas central to contemporary medical anthropology. To use the tropes now common in our field, *move san* is somatically experienced and caused by emotional distress. *Move san*—for which a literal English equivalent is "bad blood"—begins, report my informants, as a disorder of the blood. But it may rapidly spread throughout the body, so that the head, limbs, eyes, skin, and uterus may all be affected. It most frequently strikes adult women; some assert that only women are afflicted. Although considered pathological, *move san* is not an uncommon response to emotional upsets. The disorder is seen as requiring treatment, and this is commonly effected by locally prepared herbal medicines.

The course and outcome of this illness, if it is untreated or unsuccessfully treated, are reported to be dismal: several of my informants speak of friends and relatives who have succumbed to *move san.* Those most vulnerable are pregnant women or nursing mothers; in such cases, chances are good that the malady will affect the quality of breast milk. *Move san* is the chief—and some say the only—cause of the *lèt gate,* or spoiled milk, syndrome: "bad blood" is held to make it impossible for a lactating mother to afford her infant "good milk." It is thus a frequently cited motive for early weaning, which, in rural Haiti, often has disastrous effects on the infant's health. The chief effects of *move san,* however, are judged to be manifest in the mother.

Although I first encountered the *move san/lèt gate* complex in 1984 while doing research on childrearing in peasant families, its significance as a perceived threat to health was not clear until research conducted during a 1985 census revealed a 77 percent lifetime prevalence rate of *move san* (with or without *lèt gate*) in Do Kay, a small village in central Haiti and the site of most of the research reported here.

Move san has not been systematically studied, nor have thorough case studies been presented in the anthropological literature on Haiti.[2] The disorder is of interest to medical (and psychological) anthropology for several reasons, many of them obvious. Those who suffer from *move san/lèt gate* cite it as a danger to the health of women already beset with intractable and unrelenting difficulties. Child health specialists from several traditions would maintain that *move san,* like all other motives for early weaning, constitutes a threat to the health of infants. The disorder joins a long and varied list of conditions in which women question their ability to breastfeed.[3] But *move san* and *lèt gate* are more than ethnographic exotica or public health nuisances. The significance of the syndrome lies in the fact that social problems and their psychological sequelae usually are designated as the causes of the somatically experienced disorder. For this reason, the Haitian syndrome poses a challenge to overly simplistic interpretations of "folk illnesses."

Following the suggestion of others who advise that indigenous illness categories first be studied "emically," from within their cultural context, I will consider the *move san/lèt gate* complex to be an illness caused by malignant emotions—anger born of interpersonal strife, shock, grief, chronic worry, and other affects perceived as potentially harmful. It is thus not possible to relegate *move san* to such categories as "psychological" or "somatic." This stance, which avoids the strictures of a dogmatically "medicalized" anthropology, is reconsidered in the conclusions offered at the end of the paper.

THE RESEARCH SETTING

The Republic of Haiti occupies the western third of the island of Hispaniola. After the Dominican Republic, which borders it to the east, its nearest neigh-

bors are Jamaica to the southwest and Cuba to the north and west. Haiti, born of a slave revolt that ended in 1804, is the hemisphere's second-oldest independent nation. Its inhabitants are largely the descendants of the African slaves that made western Hispaniola France's most lucrative colony. During the nineteenth century, the nascent peasantry, left to its own devices, developed richly syncretic linguistic, religious, and ethnomedical institutions. In 1982, Haiti's population was conservatively estimated to be 5.1 million, or 345 persons per exploitable square kilometer. Despite the alarming density, 57 percent of the labor force is involved in small-scale agriculture. Some 74 percent of the country's inhabitants are rural; many live in villages similar to the one described in this study. Estimates of per capita income usually put Haiti last among the countries of the Western Hemisphere, and this poverty is reflected in the health status of the nation: a life expectancy of forty-eight years and an infant mortality rate of 124 per 1,000.[4]

Do Kay stretches along an unpaved road that cuts through Haiti's Central Plateau. A small village in great flux, it has been the locus of almost all "development" efforts in the area. Consisting of 123 households in 1985, Do Kay had a total population of 677. Exactly one year later, a census by the same team revealed 11 new households, bringing the number of inhabitants to 772. Some of the increase in population is due, it seems, to the construction, since 1980, of a church, a school, a clinic, and a community bakery and the initiation of a project to make pigs available to the rural poor.

The area has a curious and ironic history. Before 1956, there was no Do Kay; the village of Kay was situated in the fertile valley of the nation's largest river. A great many of the persons now living in Do Kay then lived in an area adjacent to Kay called Petit Fond. When the valley was flooded to build a hydroelectric dam, the majority of villagers were forced to move up into the hills on either side of the valley. Kay became divided into "Do" (those that resettled on the stony backs of the hills) and "Ba" (those that remained down near the new waterline). Most villagers received no compensation for their land, nor were they provided with water or electricity. For many, the years following the inundation of their lands were bitter. As deforestation and erosion whittled away at the hills, it became more and more difficult to wrest sustenance from them. And yet Do Kay is typical of many small Haitian villages in which the great majority make a living by tending small gardens and selling much of their produce. Marketing is largely the province of young to middle-aged women, many of whom are also responsible for growing their merchandise.

The majority of the houses comprise two rooms: a *sal* with chairs, and a *cham* with straw mats or, occasionally, a bed. Although average household size in Do Kay is between five and six persons, it is not unusual to find more than ten sharing these two rooms. Typically, dwellings are constructed of stones covered with

a cement-like mud, although wattle daubed with mud is not uncommon. There is still no electricity in the area, and none of the houses has running water.

Until recently, for their water supply, residents of Do Kay were forced to scramble down a steep hillside to a large spring 800 vertical feet below the level of the road. Although villagers seemed to know the dangers of drinking impure water, the temptation was to store water in large pots or calabash gourds. Infant deaths due to diarrheal disease were commonplace. A hydraulic pump now moves springwater up to three public fountains placed along the road and also to the school and other buildings run by the church.

There is no village center or "square," although the school-church-clinic complex may be beginning to take on this function. The clinic was inaugurated in 1985 and began offering consultations with a Haitian doctor two days per week. Until March of that year, when the bakery opened, there were no retail shops or businesses, though a few commodities (canned milk, local colas, small quantities of grain) could be obtained from the handful of families known to "resell."

Excluding the doctor, all the informants cited in this research were born and grew up in rural and agrarian Haiti. They are all, by their own criteria, extremely poor. This brief introduction is intended to situate the *move san/lèt gate* syndrome, primarily an affliction of women, against the background of the daily struggles of the remarkable women of Do Kay.

INTERVIEWING METHODS, CASE-FINDING, AND SURVEY RESULTS

The research on which this paper is based was conducted as part of a larger study of childrearing and nutrition in rural Haiti. When the study was initiated in 1985, I restricted in-depth interviewing to Do Kay. I had already lived in the village for over a year and knew many of its inhabitants. Other researchers working in Haiti have found familiarity with informants to be crucial to obtaining reliable data.[5] Initial interviews indicated the modal weaning age to be eighteen months, and so I decided to interview the mothers or primary caretakers of all children eighteen months and younger. By September 1985, there were forty-seven such infants in Do Kay. Interviews with mothers were preceded by three lengthy "pretest" interviews with tried-and-true informants (such as Mme. Kado,[6] introduced later) who had helped me in the past. Most mothers (or primary caretakers) were interviewed, in their homes, more than once in 1985.

Although the interviews were open-ended and followed no rigid format, several issues were always addressed. Among these were *move san* and its relation to breastfeeding. As the significance of the disorder became manifest, I devoted more interview time to its characterization. Among my informants were three

women who claimed to be experiencing *move san* at the time of the initial interview. These were considered "active cases." Two of the three were attempting to breastfeed infants; these women were interviewed several times over twenty months.

For purposes of this preliminary discussion, it is necessary to indicate that a startlingly high percentage (thirty-six mothers, or 77 percent) of those interviewed had experienced at least one identifiable episode of *move san*.[7] Thirty-two of the thirty-six, or 89 percent, sought treatment in the professional or popular health sectors: three went to a biomedical practitioner; thirteen consulted only a *dokte fey* or other herbalist; sixteen sought treatment from more than one source (although recourse to an herbalist was almost always included in the quest for therapy). In the majority of cases, professional care was preceded and then supplemented by home health care.

The central problematic of this paper is not, however, *move san* as an isolated disorder, but rather the *move san/lèt gate* complex. Of the thirty-six women who had experienced at least one episode of *move san,* seventeen, or 47 percent, stated that they had been breastfeeding an infant during an episode. (Of the three women who remarked that they felt that their lives had been in danger, two were among this group.) Of the seventeen, fifteen sought treatment outside the home for (or, in two cases, to prevent) *lèt gate*. One woman who had not sought treatment outside the home was one of the three respondents who had *move san/lèt gate* at the time of the 1985 survey; she was gathering the funds necessary to defray her treatment expenses. The other respondent was treated effectively at home, by her mother's sister. Ten of the treatment regimens for *move san/lèt gate* met with success; these women declared that they had been "cured" by the remedies. The remaining six all weaned their children, citing *lèt gate* as the motive; only two of these six children were normal weight for age by the Gomez scale, a widely used measure of childhood malnutrition.

In all cases, the etiology of the *lèt gate* was held to be *move san;* in other words, their association, which was guaranteed by the methodology, was never labeled as chance by an informant.[8] The etiology of *move san* itself was invariably seen to be a malignant emotion, most commonly caused by interpersonal strife. Of the thirty-six informants with a history of *move san,* twenty-four cited such strife as the cause of the disorder. Seventeen of these conflicts involved a spouse, partner, or family member (in descending order of importance: husband or mate, brothers and sisters, parents and children); five involved *vwasinay,* or neighbors; and two involved near or total strangers. Of the remaining twelve informants with a history of *move san,* there were five related cases of shock (*sezisman*), and the other seven adduced a mixed bag of stressors, most related to chronic financial problems (for example, shame at being unable to feed children), all of which had

led to "too much bad emotion." Distinctions between personal and social stressors seem significant, but I have not yet discerned any clear pattern of course or outcome that might be related to such differentiation. No clear symptomatology for *move san* emerged from the preliminary readings of the interviews.

CASE HISTORIES

Given that *move san* is a common problem among the mothers of children under eighteen months of age in Do Kay, what is the natural history of the illness? What are the psychological concomitants of "bad blood"? Who is at risk? How long does it last? What are its symptoms? How is it treated? Why do some women find successful therapy, while others do not? These were among the questions that led me to elicit more psychologically detailed case histories from the three women afflicted with *move san* at the time this study was initiated. Because I knew little about the perceived course of the illness, it seemed imperative to follow the cases over long periods of time. Two of these histories are presented here, the first in detail because it is a good example of the common scenario in which the label *move san* is invoked. It is also prototypical[9] in that it illustrates what appears to be the classical course of the disorder. The second case is one in which the *move san/lèt gate* syndrome was caused by "shock" (*sezisman*) or fright; though far less frequently invoked as precipitating the disorder, it was the second most common etiology given by my informants.

Case 1

Ti Malou Joseph, thirty years old, has had recurrent episodes of *move san;* each has been precipitated, she readily avers, by discord with the father of her children. She and her living children brought to a total of thirteen the number of persons sharing her parents' two-room house. Although I have only indirect indicators of socioeconomic status, the Joseph family is considered one of the poorest in the village. The house is roofed with tin, but the floor is tamped dirt. Both of her parents are frequently ill, and Ti Malou and a younger sister are usually the major breadwinners for the family. To generate income, they engage in small-scale gardening and the buying and reselling of produce and staples such as raw sugar. Often, Ti Malou lacks the (very small amount of) capital necessary to participate in the rural marketing network. Currently estranged from the father of her children, she is emblematic of the uncounted Haitian women who labor against increasingly dismal odds.

Ti Malou was interviewed several times. The first session took place late in the sixth month of her fourth pregnancy. When asked if she had ever suffered from *move san,* she replied that she had, asserting that she was experiencing it at that very moment. (Another informant, Mme. Kado, had hinted that I would find an

active case in Ti Malou.) When asked to describe "the problem," she explained, "I think the problem is the result of fighting with the father of my children. He hit me, a pregnant woman, and made life very difficult for me." Several months after the birth of her child, and two months after being cured, Ti Malou had not significantly changed her ideas about etiology:

> If you're having troubles (*nan kont*) with someone, and they yell at you or strike you, you can become ill. My illness is the result of fighting with the father of my children. He struck me while I was pregnant and rendered my life very difficult. He struck me in the face. That's what makes the blood rise up to my head and spoil the milk; this happened during my fifth month, and by five and a half months, my *move san* had already erupted [in *bouton,* small, raised blemishes] all over my body. The blood mixes with the milk; if it reaches the uterus, it will kill you rapidly.

As her pregnancy progressed, Ti Malou became more and more uncomfortable. She complained of severe lower-back pains (*doulè senti*), muscle cramps, headaches, dizziness, light-headedness (*soulay*), diarrhea, and crampy stomach pain. She endured a month or so of these symptoms, seeking no care outside the home or family friends. By the end of her seventh month, she was "unable to get out of bed." In early July, she began experiencing tingling and then "numbness" in her legs. She fell one day "because I had no sensation in my left leg." In mid-July, a full month before her expected date of confinement, she began experiencing what she described as "labor pains":

> It wasn't my time, but something was happening. I thought they were labor pains (*tranche*). I began to worry about the fall (*sò*) I had taken. Madame Kado told me that I was carrying twins, and that one of them had been damaged when I fell. I suspect now that it was not the fall that was responsible for the death of one of them. That might have left a mark on the child, but it wasn't severe enough to kill her. I went to see the doctor [in Mirebalais, a nearby town], but he said that there was nothing wrong, and that the baby wasn't due yet. He didn't think there were twins.

Mme. Kado, an influential friend, had informed Ti Malou that her symptoms were "in large measure" due to *move san;* by the end of the pregnancy, her mother and other family members agreed. Herbal remedies, the therapy of choice, were interdicted during the pregnancy, because "the medicine is too strong for the baby." During her final month of pregnancy, Ti Malou was in bed more often than not. Everyone agreed that she looked ill; more than one member of her family remarked that she was "as white as a person with tuberculosis."

When labor pains did begin, it was decided that she should go to the hospital to deliver rather than having the usual home birth attended by a midwife. There were bound to be complications, according to Mme. Kado. Late one evening, about a week after her "date," Ti Malou and her mother left for the hospital in Hinche,

about an hour away. They paid for a space on one of the trucks that carries produce and its vendors from the Central Plateau to Port-au-Prince and back again.

Rumors drifted back to Do Kay throughout the next day, with many versions of the story of her labor and delivery. All agreed, however, that the process was bedeviled from the start. One of Ti Malou's younger brothers followed them the next morning; he returned that evening, bearing bad news. His sister was "bleeding," he said, and needed a transfusion. This she would not receive without prepayment. The news was greeted by Mme. Kado and other friends (myself included) with horror. The requisite fifteen dollars (more than a month's income for many rural families) was collected in short order and dispatched with a kinswoman of Ti Malou. The next day we heard nothing. Mme. Kado feared the worst and suggested that *move san* was also to blame for Ti Malou's complications. On the third day of her hospitalization, Ti Malou gave birth to twins: one, Jules, was alive and well; the other was stillborn.

Her subsequent case of *lèt gate* was seen both as a confirmation of the *move san* diagnosis, if anyone doubted it, and as a further indication of the severity of the episode. Most of her symptoms persisted, but she delayed a trip to the *dokte fey,* or herbalist, citing financial worries. Ti Malou's father prepared a root-and-leaf concoction, but her relief was short-lived. The family became concerned that her breast milk would "pass" into her head and make her "crazy" or kill her. (No one in the Joseph family other than Ti Malou mentioned the uterus.) Three weeks after Jules's birth, he too broke out in *bouton.* He grew listless and stopped gaining weight.

Mme. Kado and others indicated that it was "scandalous" that Ti Malou had not yet attended to "their" illness properly. Mme. Kado recommended a midwife about an hour's donkey ride from Do Kay; she was reputed to be adept at curing *move san/lèt gate.* Her rates were more reasonable than those of a *dokte fey,* but her results were as good. Finally, Ti Malou did go in search of the indicated root-and-leaf remedy. (Such an interaction is depicted by the midwife later in this study; see "The Healer's EM.") Ti Malou also made a second visit to the doctor while she was a *ti nouris,* as a mother is known for the first several weeks of nursing. Although the visit was only a few days before her trip to see the midwife, she again did not mention her disorder to the doctor. Her chief complaint, he reported, was a fungal infection in the infant's throat.

Case 2

Alourdes Surpris is the twenty-three-year-old mother of one of the most malnourished children in the village. At eleven months, her daughter Acephie weighed 5.7 kilograms; by the Gomez scale, she suffered from third-degree malnutrition. Although at the time of this writing Acephie is less malnourished, developmental delays are evident. Surprisingly, the child would seem to be one

of those least at risk of nutritional disease: she lives with both parents in a three-room house directly across the street from the school. Her father is a schoolteacher and nets a small, but regular salary; Alourdes works in the new day care center and has received several years of formal education. Although the couple was not married when the child, their first, was conceived, both reported wanting a child very much.

How did this unlikely candidate become malnourished? The cause was probably early weaning: "I weaned her at five months. When she was born, I breastfed her, but my milk dried up; I had to wean her right away." Alourdes's notion of why her milk "dried up" is quite specific:

> I have had *move san* ever since a bolt of lightning struck my house and narrowly missed killing my husband and child. . . . It knocked us right out of bed. I was shocked (*sezi*) so much that I could never breastfeed again. I couldn't concentrate, I couldn't fall asleep. Whenever the baby cried, I'd jump. My heart was skipping. Even though I took a great deal of [herbal] medicine, my milk was never restored.

As noted earlier, five of the seventeen cases of *lèt gate* due to *move san* were caused by *sezisman.* Although further study is clearly necessary, it seems as if the course of *move san* is similar regardless of the source of the malignant emotion perceived to have caused it (for example, interpersonal strife, economic pressures, natural cataclysms). The healer I interviewed remarked that minor changes in the remedy are called for if the *move san* is caused by shock, though not all informants made such fine distinctions.

MOVE SAN/LÈT GATE AS "INTERPRETED DISORDER"

In a critique of methodologies grounded in an "empiricist theory of language," Byron Good and Mary-Jo DelVecchio Good suggest that an analysis of indigenous illness categories should include both an investigation of the sociocultural construction of illness realities and the analysis of the "semantic networks" that link "key public symbols both to primary social values and to powerful personal affects."[10] To put it somewhat differently, a symptom may be thought of as a vehicle of meaning that connects two different kinds of referents—the traditionally expected ones and the unexpected, "private" ones. As the first of several steps in the analysis of the *move san/lèt gate* complex, I will adopt a meaning-centered approach that encompasses both the more psychological as well as the more somatic components of a disorder that defies facile Cartesian classification. My task is not only to describe both shared and idiosyncratic meanings but also to answer some of the key questions listed at the outset: What is the natural history of the illness? How long does it last? What are its symptoms? How is it treated? Why do some women find successful therapy, while others do not? What sorts

of emotional upset are most frequently associated with the illness? What triggers these emotions? Who is at risk?

One means by which semantic networks may be evoked—and an understanding of the construction of an illness experience approached—is through eliciting informants' explanatory models, or "EMs," to use the accepted shorthand.[11] Because such an approach takes informants' discourse seriously, it entails literal and liberal quotation. It attaches narrators to narratives and recognizes discourse as context-dependent. Space restrictions limit our discussion to one case, that of Ti Malou. (As a matter of convenience, I often refer to her as "the patient.") Although her case history, presented earlier, pointed out many facets of her EM, we have not examined in detail, much less contrasted, the discourses of the patient, her friends and family, and her healers. Those engaged in the clinical process include at least a confidante (Mme. Kado), the patient's mother, a midwife/healer, and a physician. Each was interviewed at length at least twice during the illness episode.

My analysis is also meant to be mindful of three fundamental charges that have been leveled at interpretive medical anthropology. Much of the material published to date has been narrowly focused on "the doctor/patient relationship." I thank my informants for making it clear that the doctor's EM was far less relevant to their own constructions than were the other EMs presented here. Further, slighting the individual psychological nature of the illness begs the entire question of intracultural variation. Finally, study of EMs too often ignores the fact that they change over time. Not only are explanatory models reformulated and even re-created during the same illness episode; they also may be reshaped in different contexts at the same point in the episode. The cases presented here have been followed over twenty months. Interviews with older women added a greater time depth than my own recent involvement could afford. The concluding section examines in more detail the correctives that a multiply-situated discourse and its inferred connections can bring to interpretive exercises.

The Patient's EM

Ti Malou's EM might be described as "somatosocial." Although she gave the *move san/lèt gate* complex a social etiology, Ti Malou tended to focus discussion of her illness on her shifting symptoms and on the pathophysiology and course of the illness. To cite an interview following her successful cure:

> I've had it before; my life has been full of problems like this. The first thing I noticed was a bumpy rash [*bouton*] that erupted all over my body. After that, I felt terrible; I couldn't sleep, I had no appetite, and I had diarrhea. I tried treating the diarrhea with clinic medicine, but it wasn't until I took the herbal remedy [over three months later] that I was really free of it. I also had a terrible headache, and my jaw was stiff and difficult to move and my mouth was always full of water.

Her selectivity is not to be mistaken for "lack of insight" or reluctance to confront "interpersonal" difficulties: when questioned, she unhesitatingly cited the social and psychological origins of her distress. But in her more unprompted discourse, she tended to dwell on her discomfort and her quest for treatment.

Another aspect of the treatment described most fully by Ti Malou was the necessity of separating blood from milk before therapy could be successfully initiated:

> As soon as the child was born, I knew that the milk was no good. My father went in search of a medicine for me to drink. I did indeed drink it, but it had no effect, because my father did not know to separate the blood from the milk . . . before making me take the remedy. It was the midwife who began by separating blood and milk. Only when this was achieved did she start me on the remedy.

When asked what was wrong with her milk, Ti Malou responded that it had become "weak, watery" and had been "invaded by bad blood." When asked quite pointedly what had caused her blood to go bad, she readily replied, "Emotion" *(emansyon). Move san* and *lèt gate,* it is clear, are embedded in social interactions. As noted, interpersonal strife is designated as the cause of most cases of *move san*. The household *(menaj)* is the context in which the majority of these cases occur. In Do Kay, at least, a woman's husband or lover is not infrequently regarded as a potential agent of discord. So it was with Ti Malou. One striking aspect of the nature of the interaction between Ti Malou (and her friends and family) and the man who is held to have caused "all her problems" is the considerable comity that marks their every public exchange. This important point will be considered more fully later.

The Mother's EM

In 1985, Jesula Joseph thought that she was approaching her fiftieth year, "but I don't pay much attention to things like that." Indeed, more pressing dilemmas crowd her life: thirteen people to feed, more than half of them children; her own considerable health problems, which include deteriorating vision and chronic back pain; her sickly husband's inability to work; a leaky roof and a rainy season; and two sick grandchildren. Ti Malou's illness arose against a backdrop of unremitting struggle. In our first session, conducted a week before I first interviewed her daughter, I thought I detected a resignation that bordered on lack of interest: "I don't know. Sometimes when you're pregnant it's like that. Some women have a harder time bearing children. It's God's will. I don't know. Maybe it is weakness (*feblès*)." Later in the same interview, when asked if she thought her daughter might have *move san,* she expressed doubt: "I think it is a difficult pregnancy, not *move san*." A month later, she stated that a third-trimester fall had caused many of Ti Malou's problems.

A few days before Ti Malou's confinement, however, her mother was confident that *move san* was at the root of her daughter's symptoms. Mme. Joseph's "lack of interest" dissipated as the family came to perceive Ti Malou's problem as their greatest worry. Mme. Joseph's comments remind us of the need to adopt a more process-oriented approach to the study of illness meanings. Five months and three interviews later, it had become clear to me that her central etiologic interpretations had been revised at least three times during that period. What was at first a difficult pregnancy (later exacerbated by a fall) came to be redefined as *move san,* and finally as the full diapason of *move san/lèt gate* triggered by a malevolent lover. Close attention to the temporal sequence of the revisions, as well as the changes in Ti Malou's EM, led me to believe that the persuasive force of Mme. Joseph's conceptions had been overshadowed by those of Mme. Kado's EM, examined next.

A Confidante's EM

Madame Anita Kado, a fifty-one-year-old widow, is the mother of nine children, seven of whom are living. She is a cook and an aide-de-camp to the priest who runs the school in Do Kay. She considers herself a resident of Mirebalais but has long spent most of her time in Kay. A presence there for over a decade, Mme. Kado now wields considerable influence. As the daughter of a midwife, she has a longstanding interest in health issues. She is clearly a member of what might be described as Ti Malou's health management group.[12] As far as I know, Mme. Kado was the first to suggest that Ti Malou's difficulties were due to *move san*. By the end of the pregnancy, everyone agreed that Ti Malou was suffering from the disorder and that it had to be treated as such.

Mme. Kado, always an excellent informant, had a good deal to say about *move san*. These quotations are from an interview that took place shortly after Ti Malou's effective treatment:

> If you have an argument or a fight with someone, and if [that person] yells at you while you're pregnant, when the child is born, it will have problems. If he doesn't have diarrhea, the sickness will cause *bouton* to erupt all over him. This indicates that the milk is spoiled. The baby will continue to nurse, but the milk isn't good for him and will give him diarrhea. It's necessary to wean the baby temporarily. If nothing is done about it, even the next child will be affected. A remedy is necessary. You must find a person who knows how to make the medicine, and get two or three doses—enough for about four days. The baby needs to start nursing again for the remedy to work properly. You don't have to give the baby any medicine; he'll take it from his mother's breast, it will reach his blood and take away the bad milk he's already consumed. When the diarrhea starts to go away, you know that the milk is starting to get back to normal. If the diarrhea persists, the milk is still spoiled.

I asked her if babies ever died from *lèt gate*.

> No, never. It's the mother who can die. Ti Malou is a good case. If you're not getting along with someone—perhaps you've said something bad to her, and she becomes angry with you or upset and starts to cry, she can have *move san*. With someone like Ti Malou, it was clear that she began to have *move san* after Luc hit her. But for some people, the first sign is after the baby is born, when you see the milk is no good. If the spoiled milk mixes with the mother's blood and then reaches her uterus, she can die. The milk can go to her head and make her crazy; it can even give her diarrhea as it does the child. It begins to dominate her until it gives her a very serious illness. If that happens, she will surely die.

How can one be sure that a baby's *bouton* and diarrhea are caused by *move san?* Mme. Kado's response was characteristically confident and empiric:

> Well, we knew the milk was no good: it was as clear as water. But to make sure, express some of the milk into a large spoon; if it's thick and white, it's probably not spoiled. Take the spoon and hold it over a flame. As it begins to boil, put a small twig in it. If the cream climbs up the stick, the milk is good. If it doesn't make cream, it's no good. But it's usually not necessary to do this.

The worthlessness of "thin" or "watery" milk is a theme that recurs not only in Mme. Kado's discourse but in that of most of my informants. Two women expressed breast milk into a cupped hand to demonstrate the patently inferior quality, in their eyes, of their milk. These adjectives were held in contradistinction to their antonyms: thick versus thin or watery, opaque white versus clear, strong versus weak, healthy versus unhealthy. The oppositions became a leitmotiv that ran through many of the interviews; as the healer's explanations make clear in the following section, they extend analogically from the body physical to the body social.

Opinion was split as to the cause of the stillbirth in Ti Malou's case, but the disorder was widely held to have complicated labor and delivery. Mme. Kado suggested that *move san* had been at the root of the problem:

> The milk begins to build up early in the pregnancy; it is spread throughout the body, like the blood, but must never mix with blood. In the girl's case, not only did the blood and milk mix, which made the milk turn (*tounen*), but I think it may have started to infiltrate the uterus (*lanmè*). This is very dangerous; she's lucky to have escaped. The guy probably did this on purpose.

Although Ti Malou and her mother were willing to state that the problem was *move san* and that *move san* is caused by emotion, they were less willing to discuss in detail the nature of the discord that engendered the malignant sentiment. Mme. Kado, on the other hand, was full of theories:

> Certainly, it may have been only the emotion that turned the milk, and made it leave its place. But when the illness is so bad (*rèd*) that a baby dies, you begin to think that the bad person did more than yell at the woman. It's usually the *woman* who is sick with simple *move san.*

When asked what she intended by her comment, Mme. Kado hinted that Ti Malou's former consort may have tried to "poison" her. Further, Mme. Kado confided that Ti Malou's mother had similar suspicions. (On a subsequent interview of the patient's mother, I found that she had indeed come to believe that her daughter was the victim of maleficence.) When Mme. Kado was asked to fully explain what she meant by "poison," it became clear that she was not speaking of a toxin. She illustrated with a personal scenario:

> I had nine children, and I lost two. With the one who died when she was eleven days old, it seems as if it was a bad person *(move moun)* who did the damage [lit. "tempted it" (the fetus)] while I was still carrying the baby. This person gave me something, but I had no idea: I thought she was my close friend! She cooked for me, I cooked for her . . . she was always over at the house. And then she gives me a bit of *joumon* [a Haitian squash] during the very week that I gave birth. . . . On the seventh day [postpartum], things started going wrong. . . . I thought the baby was uninterested in nursing. She was not yet sick, but she was about to be. When I got up very early the next morning, her jaw was locked shut *(machwa-l te sere).* . . . When she reached the eleventh day, at four o'clock in the morning—the same time that she fell ill—she died. And when she died, out came the bit of *joumon,* exactly as I had eaten it.

Mme. Kado reports that the "bad person" is still living in Mirebalais. When I asked whether she still spoke to the perpetrator of the crime, she expressed surprise at the question: "Do I still speak with her? Of course! With people like that, you never let on that you know they're no good. If you do reveal that you know how bad they are, you'll never have children."

Mme. Kado's anecdote raises more questions than it answers. Did Mme. Kado have *move san* after this event? "Not really," she replied, "although I did take a leaf-and-root medicine to prevent my illness. I'm not very susceptible." Why not? What factors render Ti Malou more susceptible to the disorder (or Mme. Kado less susceptible), or does the difference reside in the precipitating events? How often does *move san* involve malevolent poisoning or magic poisoning? Mme. Kado felt that "you don't have to have a bad person trying to do something to you to have *move san,* but it happens like that sometimes." Some of these questions will be addressed later in this study.

The Healer's EM

Mme. Victor is known as a midwife who is knowledgeable about herbal remedies; she is not, however, a *dokte fey.* She does not know her age but looks to be at least

sixty. She lives several miles from Kay in a very modest two-room house. When I interviewed her there, slightly more than two months after she had seen Ti Malou and cured her, she had just returned from delivering a baby. She remembered Ti Malou's case vividly, although she had met her client only once before the therapy. I did not ask how much she charged to cure Ti Malou, but Mme. Kado had estimated that her fee was about five dollars.

Her notion of etiology was not too different from those detailed earlier, although she contended that *move san* is not exclusively a woman's disorder:

> Anyone can fall ill with *move san;* it happens mostly to women, but it can also happen to men. If you are deceived, cheated, cuckolded, ostracized, or frightened, you must beware of *move san.* It can happen in a short amount of time; within a week you're very ill. The first thing you notice is an eruption of itchy bumps all over your body. Then you might have a headache, fever . . . your mouth becomes dry, you're very jumpy . . . your blood turns into water, and you feel weak or stiff. . . . A person with *move san* can sleep all day long. If you press on your nails, you note that there's no blood under there, and you know then that it's turned. Your eyes also turn white. If you're poor enough, you'll feel that you still have to go work in your garden, but if you let the sun cook your already watery blood, it will make it all worse. You become like a leaf: more and more withered. Soon you don't even look human. . . . If the victim is a nursing mother, the milk's as good as lost; it goes bad. You need the [herbal] remedy to make new milk. As soon as you've finished the first day or so of medicine, you can expect the milk to start coming down beautifully, then the headache will go away, as will the body stiffness.

Mme. Victor's discourse was rich in details, which is not surprising given her professional interest in the disorder. The theme of weak or watery blood is again linked to poverty, which is widely held to exacerbate *move san.* Botanical metaphors pepper her descriptions, which are also rich in herbal lore. Mme. Victor was quite willing to share her knowledge and even expressed a willingness to cull some of the scarcer ingredients. Her recipe was presented as a precise and somewhat ritualized regimen:

> To make the remedy, you soak the roots of *bwa lèt,* the roots of *kayimit, bwa jon,* and coconut, and the leaves of *sorosi* and *fey sezi.* If the person with *move san* is a woman with a nursing baby and her milk has gone bad, you need to add the leaves and roots of *bwa let* and also to add one small spoonful of the spoiled milk to the bottle [that contains the remedy]. This is for the person to drink, and will separate the blood from the milk. . . . But there's more to it than that: you must buy a piece of white soap and a coconut, a bit of coffee, a measure of black beans, and then you bring down the blood (*fe lèt la desann*). You grill the coffee together with the black beans and seven grains of salt. When you've finished grilling, you grind it up in a mortar and put it in a pan, add water, and mix it up. From this you make a compress for both the brow and the back of the head, and keep it moist with the

> concoction all day long. . . . You can also place an empty shallow basket on the person's head and pour the medicine in the basket; it will run down over the head and body. Each time you dampen the compress, also rub down her arms and legs with the medicine. Do this for a week or so. Also put a grain of virgin salt [from a box that has not been used for cooking] in the palm of each hand. Place a grain of salt under each of [the patient's] feet and stand on a palm leaf. She must stand still. This will make the milk return to its rightful place.

Mme. Victor mentioned that there were several variations on this theme, but that these were the "principal ingredients." Some of these versions are designed to alleviate particular symptoms. (If swollen feet are part of the symptom cluster, Mme. Victor adds avocado-tree bark to the mixture.) A slightly different formula was indicated if the *move san* (or *lèt gate*) was caused by *sezisman*. Further, it is perfectly acceptable for someone suffering from *move san* to seek medical care from other practitioners, with the following caveat:

> The medicine I'm telling you about is the best one for *move san,* and you'd better take it before you spend your money to go to the hospital, because hospital medicines can't make the milk go down. After this remedy has made the milk go down, then you can go to the doctor.

Although such herbal remedies are clearly the therapy of choice, there are attendant risks:

> Don't put in too much of the ingredients. . . . If it's too strong, or you give her too much of the medicine, it can make the person go crazy. But if she doesn't take the medicine, the milk mixes with the blood, it rises to the head and that makes her crazy anyway. That's why nursing mothers are more susceptible, and when you don't see any milk, you'd better hurry and take the [herbal] medicine because you can be sure that the milk is going to her head and will kill her.

Further, the family of the sufferer must ensure that no repeated emotional shocks "interrupt the treatment. . . . The weak has to become strong." Unlike Ti Malou and Mme. Kado, Mme. Victor said nothing about the "infiltration of the uterus." When asked about the case of Alourdes (our second case study), who followed a similar regimen without results, Mme. Victor's disapproval was evident:

> If she weaned her baby, she has narrowly missed killing herself; it's the baby who makes the medicine work correctly. The infant sucks out the bad milk and can then be given a purgative (*lók*). Then both mother and child get well together. But if she has *move san* and doesn't take the right medicine, and the milk dries up within her and the child is weaned, she might look healed today, but she'll be sick again tomorrow.

After interviewing two *dokte fey* and several women with a history of successfully treated *move san/lèt gate,* it became clear that the most constant ingredient

in the remedy for spoiled milk was *bwa lèt*. Literally "milk tree," *Sapium jamaicense* exudes an opaque white sap when nicked or broken. Since Haitian ethnobotany so strikingly recalls a more famous "milk tree," I turn to Victor Turner's analysis of Ndembu ritual. He reminds us to seek three classes of data when attempting to analyze the structure and properties of ritual symbols: "(1) external form and observable characteristics; (2) interpretations offered by specialists and laymen; (3) significant contexts largely worked out by the anthropologist."[13] Observable characteristics as described by Mme. Victor seemed to typify those of other healers. The interpretations of "laymen," who were all women, tended to be rather thin when compared to the explications offered by Mme. Victor. A typical lay response: "The *bwa lèt* separates the milk from the blood; it makes the milk come back to its place. It strengthens the milk, too, and makes it thick again. The nursing child draws the new milk down into the breast."

The "significant contexts" slowly emerge with repeated interviewing. I attempted to answer basic enough questions: Why might two of our most vital constituents, blood and breast milk, be perceived as potential contaminants? Why would blood become a poison that can mix with breast milk and "climb" into the head or "descend" to the uterus with mortal effect? But before considering this illness in its symbolic register, let us explore the empirical meaning it holds for an "outside authority"—the village's visiting doctor.

The Doctor's EM

Dr. Jean Pierre is a thirty-five-year-old graduate of his country's only medical school. He has been practicing in rural Haiti for almost five years, since the completion of his year-long residency in a small city in the south of Haiti. After moving to the Central Plateau, Jean worked exclusively in the nearby town of Mirebalais; more recently, he has been spending two days each week in the new clinic in Do Kay. I have worked with him for over four years and know that he is from a middle-class family from the country's southern peninsula. Although he was raised by strict Catholic parents, attended parochial schools, and considered becoming a priest, he avows an interest in voodoo. His grand-uncle was a well-known *houngan,* or voodoo priest, in the area where Jean was raised. Despite professed interest in the local religion, Jean more often seems bemused by his patients' health beliefs.

Dr. Pierre saw Ti Malou twice: once in Mirebalais during her "false labor," and again a month or so after her hospitalization. During both visits he spent no more than five minutes per session with Ti Malou. Although I did not tape-record our discussions of her case, I did make the following note at her first consultation:

> Jean states that Ti Malou is in "false labor," but that otherwise her pregnancy is progressing normally. He attributes most of her problems to folate deficiency,

> although I informed him that she was receiving 1 mg/day of folate supplement. The backache is due, he says, to the normal loosening of pelvic ligaments; the leg problems are sciatica from the same cause. When asked about *move san,* he laughed and said, "Everyone has *move san!* Her blood is 'bad' because she needs more folate and iron. Besides, there's nothing I can do about such disorders." He said that she did not bring up the issue with him, but spoke only of her back pain, diarrhea, a numbness in her legs, and of course the "labor pains."

Worth noting throughout these exchanges are, first, the degree to which the EMs of the patient, the mother, the confidante, and the local healer converge, and second, how little these have in common with the EM held by the doctor. Ti Malou knew very well that, in the clinic, complaints of *move san* were more likely to elicit scorn than sympathy. Again we are reminded that discourse depends on a setting for much of its meaning; rather than being neutrally descriptive, it always interacts performatively with a setting of expectations and admitted interpretations. The patient later insisted that her own etiologies were "too private" to discuss in front of the doctor. When I countered mildly that her disorder did not seem too private in Do Kay, she responded much as Jean had done: "There's really nothing he can do, anyway."

That the EMs of all those who accepted the reality of *move san* disorder should have so much in common ought not to surprise us. *Move san* is a "public health problem" in an unaccustomed sense: an illness with a public meaning. When a whole village knows the participants and follows the course of treatment, a case of *move san/lèt gate* serves as a stage on which social and psychological problems (mistreatment of pregnant or lactating women, for example) can be aired. The doctor refused to admit *move san* into the range of his competence, and the patient tacitly agreed to act as if the disorder had never occurred. Doctor and patient were not, therefore, speaking the same language.

Momentarily putting aside the doctor's opinion of the disorder's etiology and cure, we might sum up the villagers' shared understanding of the *move san/lèt gate* complex as including the following points:

- A "malignant" emotion can cause sickness. Such emotions include anger, fright, and shock. Women who contract the illness are more often perceived as victims than as offenders.
- Pregnant and lactating women are particularly susceptible to *move san.* They should therefore be protected from these malignant emotions.
- If *move san* does occur in a pregnant or lactating mother, one common outcome is "spoiled milk."
- With or without *lèt gate, move san* is appropriately but not always successfully treated with an herbal remedy.

> Body fluids like milk and blood are perceived as especially sensitive to "malignant" emotions; disorders involving them can therefore be seen as "barometers" of disturbances in the social field.

This last point, bringing physiological, pharmacological, psychological, interpersonal, and moral forces to bear on the etiology of *move san,* ought to be singled out as just the sort of emphatically loaded cultural *donnée* that an anthropology of suffering needs to examine. In this context, it is significant that Hazel Weidman wrote of a "blood paradigm" that seemed to underlie many of the health-related beliefs of her Haitian American informants.[14]

While a socially recognized disorder like *move san* in some regards resembles a code by which private messages are made public, this should not make us forget that a code can contain personal or regional "dialects," "styles," or "idioms." In Ti Malou's case, we can see personal meaning at work: her illness seems to chart the history of her relationship with Luc, the father of her children. An uninformed observer might not notice the tension that exists between the former mates. But in Do Kay there are plenty of open secrets and forbidden subjects. I recall Mme. Kado's response when I asked her if she still spoke to the woman she held responsible for the death of one of her children: "Do I still speak with her? Of course! With people like that, you never let on that you know they're no good. If you do reveal that you know how bad they are, you'll never have children." Illnesses, therefore, might speak louder than words in contexts such as those from which the *move san* disorder takes its meaning.

One hypothesis comes to mind for certain cases in which *move san* is intractable or difficult to treat: the "illness" might in fact be "illness behavior," a form of chronic somatization that is related to strong social pressures (as, for example, the pressure to avoid confronting those who wrong you). Somatization of distress is, in such cases, a form of metaphoric retaliation or resistance. Although somatization is clearly an important component of *move san,* there are substantial differences between the somatization depicted here and that described by Arthur Kleinman among the Chinese and Margaret Lock among Japanese women.[15] Among Kleinman's Hunanese patients, depression and psychosocial problems were either denied or taken to be the result, and not the cause, of pain. Etiologies were predominantly biologic, these being the culturally sanctioned causes of illness. My informants, in contrast, almost always designated social problems and their psychological sequelae as the cause of their illness but thereafter focused on their abundant somatic symptoms. Among Lock's Japanese informants, also women, we can see more similarities: somatization of distress is a form of women's protest, but the social dynamics of distress, however obvious, are often treated as a forbidden subject. More research should show how similar these patterns are.

Nonetheless, the model of "illness behavior" is inappropriate to many of the cases described by my informants. For a few, *move san* may be more of a coping style, an idiom of distress. For others, it recalls a more acute form of somatization similar to an acute stress syndrome. But if *move san* is in some way adaptive, "the work of culture," why is the outcome occasionally so dismal? As Gananath Obeyesekere writes, "Work also implies failure; if mourning is successful work, melancholia is failure."[16] Where people are under severe nutritional, political, and interpersonal stress, attempts to replace direct confrontation with some "safer" alternative are bound to fail sometimes. Seen as "work," acute *move san* may be successful, while the *move san/lèt gate* complex is frequently a failure.

Should *move san* and *lèt gate* be considered two different syndromes? If so, *move san* seems to be an "etiological category," one that suggests much about the origins of the problem, with wide variation in presenting symptoms. Spoiled milk, on the other hand, is virtually pathognomonic for the *move san/lèt gate* syndrome when it is seen in a previously healthy woman who is not pregnant. Is spoiled milk merely the symptom of bad blood in a pregnant or nursing mother? I believe that *lèt gate* is more than just a symptom of *move san.* Instead, let us suppose, as do my informants, that the two "run together"; it is widely believed that the added factor of milk complicates the course of the malady. It indicates, I suspect, the gravity of the initial offense, the malignancy of the emotion. It recalibrates the barometer.

Further, this barometer gives readings on the larger atmosphere. Everyone in Do Kay shares a background of great material and political stress. Social interrelations and psychological equilibrium are rendered more fragile under these conditions. In much of rural Haiti, women are frequently called upon to perform the Herculean task of providing for children and other dependents. Too often, like Ti Malou Joseph, they must do this alone. During pregnancy, and while a woman is a *ti nouris,* several strict rules are observed, all seeming to reflect a single concern: the protection of the woman. One must avoid, at all costs, startling or upsetting a pregnant or nursing mother. When this "taboo" is broken, *move san* as illness behavior is one means of articulating distress. Obeyesekere asserts that the "work of culture is the process whereby painful motives and affects such as those occurring in depression are transformed into publicly accepted sets of meanings and symbols."[17] In his work in Sri Lanka, Obeyesekere sees the work of culture in the ample Buddhist lexicon of suffering and despair. But the work of culture is found not only in well-articulated ideology or flashy ritual. It is also present in a more subtle illness syndrome that may afford beleaguered women, and especially mothers, a culturally sanctioned and relatively safe means of articulating displeasure with the behavior of consociates. It becomes, quite literally, an idiom in which many forms of misfortune—whether designated by outside observers as social, economic, psychological, or physical—are obliquely presented.

Whether or not an organic basis is ever found for the *move san/lèt gate* complex, it is clearly an illness rich in cultural and individual meaning. It is for this reason, too, that a more broadly conceived approach is now appropriate.

DISCUSSION: MODELS OF AN ILLNESS

A next step in the preliminary assessment of a heretofore undescribed indigenous illness category might be to apply to it several different varieties of cultural analysis, one after another, in an attempt to clarify the nature of the illness, and then compare the results. We shall bring three possible and complementary methods of explaining to bear on *move san/lèt gate.* The first is the meaning-centered psychological and ethnomedical analysis outlined earlier. A number of the questions posed at the outset remain unanswered, suggesting, perhaps, the limitations of an interpretive approach. If it hopes to answer questions of relative risk and changing incidence, an interpretive approach not only must be based on a painstaking phenomenology of illness and grounded in epidemiology but also must incorporate the lessons of history and political economy. Further, a comparative exercise might yield insights not apparent if an "emic" stance alone is adopted. What follows is a pair of methodological sketches, the sole purpose of which is heuristic.

Move San/Lèt Gate as a Product of Economic Forces

Is the *lèt gate* syndrome the product of an economy that forces women away from breastfeeding? In 1975, an estimated 46.2 percent of Haitian women participated in the labor force, making them far more economically active than any of their Latin American counterparts. In the entire Third World, only Lesotho boasts a formal economy more dependent upon women.[18]

In their detailed study of infant feeding practices in a Haitian village they call "Kinanbwa," Maria Alvarez and Gerald Murray note an alarming increase in the "spoiled milk syndrome." Their rural informants "believed that it is possible for the milk of a lactating mother to *gate,* to spoil and turn it into a poisonous substance that may, instead of nourishing the child, harm or even kill it." For this reason, women with *lèt gate* wean their children. As in Do Kay, "the most frequent cause for this is the onset of violent negative emotional state in the female." The authors attribute the "epidemic" to the gradually deteriorating economy of the village in which they worked: "It takes little imagination to perceive the manner in which this 'illness' provides precisely the cognitive rationale for turning to the increasingly early weaning that the worsening economic conditions in the village make practically desirable. The belief complex itself makes possible a behaviorally convenient symbolic metamorphosis of the meaning of early weaning. Traditionally, early weaning was seen as an injustice to the child. But

when a woman has *lèt gate,* her early weaning is interpreted as a service to the child." Although Alvarez and Murray do not suggest a monistic economic model, favoring instead one that draws upon intimate familiarity with their informants, they do insist that "the epidemic of *lèt gate* which appears to have come over the village cannot be understood apart from the economic pressures which make early weaning desirable."[19]

It is unlikely, however, that the model they propose will fully illuminate the Do Kay data. First, although the prevalence of *move san/lèt gate* would seem to be as high among my informants as among the Kinanbwa mothers, the lactating women of Do Kay, unlike those who spoke with Alvarez and Murray, do not wean their children when their milk spoils; rather, they seek to treat it. Ten out of sixteen did so effectively. Second, in Do Kay, the threat is seen as chiefly to the mother, not the infant. One of the chief differences between the two groups of women is the Kinanbwa women's almost universal involvement in marketing, an activity that takes them to Port-au-Prince for much of the year. The women in Do Kay do far less marketing but still have a high incidence of *lèt gate.* More work is necessary to determine possible psychological and secondary "gains" derived from the *move san/lèt gate* label. Perhaps the course, rather than the incidence, of the illness is to some extent determined by the mother's occupation. No pattern was discernible among my informants: the six women who weaned their infants were no more involved in marketing than were the ten who continued breastfeeding after successful treatment.

During the past few years, a "critical medical anthropology" has taken shape. Although it seems to have no one agenda, a central criticism leveled against medical anthropology has been its failure to link local ills to the larger systems of domination that often influence or even generate them. Much psychological anthropology is vulnerable to the same critique. My own refresher course in political economy was taught by a more convincing teacher—one of my local informants. Mme. Gracia, a woman in her late sixties, insisted that I not forget recent history. She reminded me to attend to the larger context in which "malignant emotions" arose:

> *Move san* is not something that was regularly seen before [the valley was flooded]. Some people died from it after the dam was finished. Now we are up here and we are poor. We have no livestock, no [sugarcane] mills. We suffer too many shocks (*sezisman*), too many problems. We are poor and we are weak, and that is why you see *move san.*

For Mme. Gracia, as for many of my younger informants, *move san* was a channel through which broader experiences of suffering could be transmitted. That suffering is explicitly related to the humiliating frustrations of poverty, the ineffaceable pain of displacement. Mme. Gracia jogged my memory: seven of the

thirty-six mothers with a history of *move san* cited financial difficulties as the prime etiologic factor. Poverty was mentioned in most talk about suffering and misfortune. I do not believe that *move san/lèt gate* is a direct product of economic forces. But I do believe that the weight of material deprivation may change the incidence and course of the illness, and even serve as a causal factor in some instances. In many of the Do Kay cases, then, a modified version of Alvarez and Murray's dictum holds true: the high incidence of *lèt gate* in Do Kay cannot be understood apart from the economic pressures that make emotional stability so elusive.

Move San as a Mental Disorder, American Style

One of the most consistently applied methods of examining a "new" disorder is to attempt to map it onto existing illness categories. This has become especially true if the disorder is labeled "psychological." For example, Ari Kiev has declared that culture-bound disorders "are not new diagnostic entities; they are in fact similar to those already known in the West." Each of the well-described culture-bound disorders, Kiev asserts, is actually an American psychiatric diagnosis in exotic clothing: *latah* is a hysterical disorder, *susto* and *koro* are anxiety disorders, *shinkeishitsu* is really obsessive-compulsive disorder, and so on.[20] As much recent work by anthropologists has shown, there is good reason to believe such transpositions inaccurate.

False starts do not excuse us, however, from seeking a genuine dialogue with other, related disciplines. In referring to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III), we need not surrender our relativism, nor our attempts at autonomous theorizing. We can consider the textbook classifications as offering a comparative perspective, not an authoritative answer. In several circumstances, diagnoses from one nosology have served to illuminate diagnoses from another. In the spirit of such comparison, we will suspend skepticism and consider *move san* as a Haitian version of one of our own official labels. Further, the exercise is best conducted by clinically informed anthropologists with an understanding of indigenous categories, if only as a preemptive strike against those less aware of the slippery nature of categories and labels. With the growing hegemony of North American medicine in Haiti, it will not be long before DSM-III is aimed at *move san* with "therapeutic" intent.

For example, can *move san* be construed as a depressive disorder? Given the primacy of the "psychological" that is manifest in DSM-III criteria for Major Depressive Disorder (MDD), it is unlikely that any of my informants would be diagnosed as clinically depressed. If some of their somatic complaints were judged to be metaphoric expressions of sadness, however, several of them would meet MDD criteria. I am not sure that would be an appropriate or useful diagno-

sis; in those who are currently afflicted with *move san,* the affective component is more suggestive of anxiety than depression. Of the several anxiety disorders listed in DSM-III, only Generalized Anxiety Disorder (GAD) would be a candidate diagnosis for *move san.* DSM-III stipulates that the essential feature of the new category GAD is "persistent anxiety of at least one month's duration." Certainly, anxiety of one brand or another was present among the vast majority of those women suffering from *move san,* but it did not have the overwhelming character of an "essential feature" and was often of short duration. Further, anxiety is almost as prevalent among those women with no history of *move san.* Raising children in rural Haiti has become an anxiety-generating venture.

Taking the somatization of depression among the Chinese for a model, can a case be made for the somatization of anxiety disorder among rural Haitian women? DSM-III certainly makes it easier to arrive at a diagnosis of GAD than one of MDD. To diagnose the former, "generalized, persistent anxiety" must be continuously present for at least one month. Unlike the criteria for MDD, however, which are imbued with a marked primacy of the mental, the anxious mood may be manifested in symptoms from any three of the following four categories: motor tension, autonomic hyperactivity, apprehensive expectation, and vigilance and scanning.[21] Although a patient such as Ti Malou could be squeezed into a modified, "somatized" MDD category, a diagnosis of GAD might fit her more comfortably. At present, these diagnoses may not be entertained concurrently: DSM-III stipulates that a diagnosis of GAD may not be made when the criteria for MDD or any other Affective Disorder can be met. Since the publication of DSM-III, the hierarchical organization giving precedence to Affective Disorders has come under attack; Robert Spitzer and Janet Williams have reviewed the issues and propose a revision in which a "symptomatically more pervasive disorder preempts the diagnosis of a less pervasive disorder."[22]

One problem with such a "lenient" approach to diagnosis might be that, although criteria can be met using the somatic symptoms, the resulting clinical picture is not strikingly anxious. This leads, of course, to a conundrum and underlines a major source of anthropology's chronic vexation with psychiatry: none of the reported symptoms is specific to anxiety, and none of them allows us to distinguish "normal" from "pathologic" anxiety.

The APA classification holds that the essential feature of Adjustment Disorder is "a maladaptive reaction to an identifiable psychosocial stressor." The maladaptive nature of the response is manifested by "impairment in social or occupational functioning or symptoms that are in excess of a normal and expected reaction to the stressor."[23] If it falls to outsiders to decide what constitutes normal and abnormal reactions, these criteria are more easily met. Because appropriate social functioning for a *ti nouris* includes breastfeeding, and because bottle-feeding so often has adverse effects in settings such as rural Haiti, *move san* as a response to

a stressor might very well be considered maladaptive.[24] Yet this diagnosis, even if embellished by tags such as "with Anxious Mood" or "with Mixed Emotional Features," would have no real utility and would offer little in the way of improving our understanding of the disorder.

Just as it would be premature to exclude an organic basis, so too is it unrealistic to consider as psychogenic in origin any illness "for which there is positive evidence, or a strong presumption, that the symptoms are linked to psychological factors or conflicts."[25] *All* symptoms, once perceived, are linked to "psychological factors or conflicts," even those symptoms that are positively valued. More useful in a preliminary examination of *move san* is the term "somatization" as used by Wayne Katon, Arthur Kleinman, and Gary Rosen;[26] they include under that label not only physical symptoms that occur in the absence of organic findings but also the amplification of complaints caused by established pathology, such as a chronic illness. The definition eschews an unrealistic faith in the ability of clinicians to detect "underlying" organic findings or pathophysiologic mechanisms on a case-by-case basis. In over four years of intermittent clinical experience in Haiti, I have never seen anything resembling a complete diagnostic workup.

Psychological reductionism would have us miss the possibility of significant biological disruption; in addition to the medicalization of social problems (for example, neurasthenia in China, "heart distress" in Iran), can we afford to miss or misinterpret the *physiologization* of social and psychological problems? An elegant psychoneuroendocrinologic model could be advanced to explain *lèt gate* (for example, neuromodulatory inhibition of oxytocin letdown or prolactin rise), as well as the more obvious symptoms of autonomic nervous system hyperarousal. And is our own relativism not called into question by our failure to entertain the possibility that *move san* might be just what it is said to be: a blood disorder caused by malignant emotions? Among my informants, the most common explanatory model seems to go *beyond* a somatosocial model—*move san/lèt gate* becomes a disorder of experience, without a great deal of Cartesian anguish as to whether it is more somatic than psychological. The disorder, and their view of it, calls into question the tenaciously dissecting gaze not only of psychiatry but of much medical anthropology as well.

CONCLUSION: MADAME GRACIA AND THE ANTHROPOLOGY OF SUFFERING

Move san is an illness that has not yet been fully described in anthropological, medical, or psychiatric literature. How to begin? Anthony Marsella's suggestion that research start from an emic determination of popular categories[27] is accomplished by eliciting explanatory models from informants in order to clarify how the illness (often not neatly labeled "psychological" or "somatic" by the persons

who suffer from it) is culturally constructed. After this preliminary description, how should the illness be examined? I have presented several different ways of interpreting the data—some of them reductionist and functionalist, but all heuristically useful. The mapping of "exotic" disorders onto North American psychiatric-diagnostic frameworks instructs mainly through its inadequacies; it neither helps us understand the "folk" nosology nor gives any assurance that the familiar categories are being applied correctly. In the attempt to formalize imaginary correspondences, an "unreal" illness is reinterpreted to fit the authoritative terms of a "real" one.

Considering *move san/lèt gate* as an interpreted disorder affords a privileged view not only of the disorder but of broader categories of affliction. Viewed as a cultural artifact, the most striking thing about *move san* disorder is the lurid extremity of its symbolism: two of the body's most vital constituents, blood and milk, are turned to poisons. The powerful metaphors serve, it may be inferred, as a warning against the abuse of women, especially pregnant or nursing ones. Transgressions are discouraged by their publicly visible, and potentially dire, results. As somatic indices, "bad blood" and "spoiled milk" submit private problems to public scrutiny. The opposition of vital and lethal body fluids serves as a moral barometer.

Up to this point, the nonbodily factors appealed to by our analysis of the disorder have been largely interpersonal and village-scale. The investigation remains shallow, however, if the "moral barometers" are viewed in a controlled and limited context. A village is not a bell jar, and, as Mme. Gracia attests, the syndrome is related to the historical and economic changes affecting women's increasingly difficult struggle for survival in rural Haiti. In their incisive evaluation of contemporary anthropology, George Marcus and Michael Fischer reach a similar conclusion: "An interpretive anthropology fully accountable to its historical and political-economy implications thus remains to be written."[28] This is no less true of medical and psychological anthropology. It is inexcusable to limit our horizons to the ideally circumscribed village, culture, or case history and ignore the social origins of much—if not most—illness and distress. An interpretive anthropology of affliction, attuned to the ways in which history and its calculus of economic and symbolic power impinge on the local and the personal, might yield new understandings of culturally evolved responses to illness, fear, pain, hunger, and brutality.

It is often remarked that contemporary academic approaches attempt to understand by dissection. We have this attitude to thank for much of our present-day rigor, and also for the specialization that renders accurate characterization of disorders like *move san* elusive. To diagnose such an affliction as somatic, psychological, or even psychosomatic is still somewhat different from and, it may be contended, something far less than examining it as it is experienced and

interpreted. Perhaps what is necessary is a concerted and integrated effort, an anthropology that would seek underlying *forms* of suffering common to its many *aspects* (bodily, mental, economic, and so on). An anthropology of suffering would not stray far from the standard concerns of the ethnographer, for suffering strains cultural norms and brings them into sharp relief, as the Haitian material illustrates. Anthropologists are also in a position to discern epistemological and ontological differences (and similarities) between medicalized suffering and suffering that is understood in religious terms.

This is not to be mistaken for yet another call for holism. Rather, it is a reminder of the need to connect personal illness meanings with larger political and social systems. One way to approach such a project is simply to attend more closely to the way in which illness (and other misfortune) is worked into the narrative renderings of broader experience. In a 1986 study of urban, working-class France, we found that concepts such as "coping mechanisms" or "illness behaviors" were useful but inadequate to explore illness as experienced and discussed by our informants, who were mostly Iberian immigrants.[29] Pointed questions about specific episodes frequently elicited long and nonspecific narratives that seemed to address far larger, more existential questions of suffering. These narratives were typically couched in a sweeping "rhetoric of complaint," highly context-dependent and markedly performative. Illness episodes were commonly worked into this rhetoric in an attempt to make meaning out of a broader set of physical and social afflictions less easily classed as "psychological" or "physical" or "social" or "economic." That illness was often conceived in broad terms of misfortune meant that our subsequent analysis was reduced to a struggle, not entirely successful, for parsimony without reductionism.

Last come the moral dilemmas an anthropology of affliction must face. These are not new in our discipline, but they become particularly sharp when suffering forms both the subject and topic of research. Mme. Gracia made this painfully clear when I consulted her regarding the ingredients of the herbal remedy for *move san/lèt gate.* Her response, and the tone in which it was delivered, brought me up short: "Surely you are collecting these leaves in order to better understand their power and improve their efficacy?" Had she added, "If you think we'll be satisfied with a symbolic analysis of *move san/lèt gate,* you're quite mistaken," I would not have been more surprised.

NOTES

1. Scheper-Hughes and Lock, "The Mindful Body," p. 9.

2. Some of the most important research on Haitian "health beliefs" has been conducted, paradoxically, in the United States. Hazel Weidman (*Miami Health Ecology Project Report*) provides the most extended consideration of blood-related beliefs. She and her collaborators encountered *mau-*

vais sang (as interviews were conducted in Haitian Creole, the label may be considered a Gallicization of *move san*) among their Haitian American informants; this and other disorders are considered as parts of a "blood paradigm" central to informants' perceptions of bodily functioning. Also on this topic, see "Haitian Blood Beliefs and Practices in Miami, Florida," by Clarissa Scott, a member of the research team led by Weidman. In research conducted in Haiti, the disorder is also mentioned en passant by Alfred Métraux in "Médecine et vodou en Haïti." It is discussed by Emmanuel Paul ("La première enfance") and considered at greater length in an excellent unpublished report by Maria Alvarez and Gerald Murray ("Socialization for Scarcity"). In his comments on a report by Jeanne Philippe and Jean Baptiste Romain ("Indisposition in Haiti"), Claude Charles, also a member of the Miami team, examines *indisposition* in relation to the blood paradigm prevalent among his informants ("Brief Comments on the Occurrence, Etiology, and Treatment of Indisposition").

3. Interesting cross-cultural comparisons, beyond the scope of this paper, are to be made with the large literature treating disorders caused by emotional shocks, especially illnesses affecting breast milk. Unni Wikan ("Illness from Fright or Soul Loss") describes a group of illnesses called *kesambet* in northern Bali, which are very similar to the *move san/lèt gate* complex. Nancy Scheper-Hughes, working in urban Brazil, has recently described infant "death by neglect," one feature of which was perceived spoiling of breast milk. The discourse of her informants (the women of the community) recalls, I believe, that of many of the Haitian women who speak of *move san* in broad, "existential" terms (see Scheper-Hughes, "Culture, Scarcity, and Maternal Thinking"). There is also a large literature documenting the widespread belief that one's milk is insufficient, but milk insufficiency is not necessarily the same as spoiled milk, nor do we have reason to believe that perceived insufficiency is often caused by malignant emotion. For a review, see Tully and Dewey, "Private Fears, Global Loss."

4. For an overview of the country, see Prince, *Haiti.*

5. Chen and Murray, "Truths and Untruths in Village Haiti."

6. All personal names are pseudonyms, as are "Do Kay" and "Ba Kay." Other geographical designations are as cited.

7. A follow-up survey was conducted at the time of the 1986 census, revealing even higher prevalence (and thus increasing incidence) of *move san* as well as a new case of *move san/lèt gate.* It should be noted, however, that by then my interest in the disorder was well known; perhaps "questionable" cases were politely brought to my attention. Further longitudinal study is necessary to determine the chronicity of the complex and to elucidate patterns of recurrence or relapse.

8. There are, however, other causes of *lèt tounen,* or "turned milk," which often seemed to be synonymous with *lèt gate. Lèt tounen* was usually caused by the conception of another child, in which case the milk was described as "spoiled" or "turned." Many informants used the verb "to steal." One informant explained, "As soon as you become pregnant, any milk in your body must be for the baby in the womb. If the other [the nursing child] steals it, he can become sick."

9. Eleanor Rosch and others have questioned the validity of the prevailing "digital" model of categories, which assumes that "caseness" is determined by the absence or presence of discrete, criterial attributes. Instead, they propose an "analog" method that "represents natural categories as characterized by 'internal structure'; that is, composed of a 'core meaning' (the prototype, the clearest cases, the best examples) of the category, 'surrounded' by other members of increasing similarity and decreasing 'degree of membership'" (Rosch cited in Good and Good, "Towards a Meaning-Centered Analysis of Popular Illness Categories," p. 146). I present here two uncontested cases of *move san;* in some situations, *move san* is suspected to be the cause of certain symptoms, but there is not universal agreement.

10. Good and Good, "Towards a Meaning-Centered Analysis of Popular Illness Categories," p. 148.

11. Following Arthur Kleinman, explanatory models are "notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (*Patients and Healers in the Context of Culture,* p. 205). Formulated for each illness episode, EMs attempt to answer questions of etiology, type of symptoms and their onset, pathophysiology, the course of the sickness, and treatment. The methodology, when used in an open-ended way, has proven no less useful when the disorder is perceived as social or psychological in origin. Many of my rural Haitian informants were reluctant to be steered in any direction, however, and I am very tempted to refer to my transcripts as "ENs" (Elicited Narratives), rather than EMs.

12. For an evaluation of this concept, see Janzen, "Therapy Management."

13. Turner, *The Forest of Symbols,* p. 20.

14. Weidman, *Miami Health Ecology Project Report.*

15. Kleinman, "Neurasthenia and Depression"; Lock, "Protests of a Good Wife and Wise Mother." See also Kleinman, *Social Origins of Distress and Disease.*

16. Obeyesekere, "Depression, Buddhism, and the Work of Culture in Sri Lanka," p. 148.

17. Ibid.

18. Lundahl, *The Haitian Economy.* See also Neptune-Anglade, *L'autre moitié du développement.*

19. Alvarez and Murray, "Socialization for Scarcity," pp. 70–74.

20. Kiev, *Transcultural Psychiatry,* p. 66.

21. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* s.v.

22. Spitzer and Williams, "Proposed Revisions in the DSM-III Classification of Anxiety Disorders Based on Research and Clinical Experience."

23. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* p. 299.

24. Note, however, that Alvarez and Murray ("Socialization for Scarcity") discern the adaptive nature of "the spoiled milk syndrome" among their informants.

25. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders,* p. 241.

26. Katon, Kleinman, and Rosen, "Depression and Somatization: A Review. Part I," and "Depression and Somatization: A Review. Part II."

27. Marsella, "Thoughts on Cross-Cultural Studies on the Epidemiology of Depression."

28. Marcus and Fischer, *Anthropology as Cultural Critique,* p. 86.

29. Gaines and Farmer, "Visible Saints."