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Frontispiece:

Ghasem Parvaz is a *hajam* which means he is a specialist for *hajamat*. The photograph shows the traditional Shiite way of cupping with the horn as cupping instrument (see page 20 f.)

Photograph: Mohammad Shekari Yazdi

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Editorial

In this issue we present to you again projects and works from members of our society and collaborators of our Department. Hwiada Abu-Baker reports on her personal experiences in an Austrian hospital with her daughter Rahik as in-patient. Felicia Heidenreich gives us an account on her work in a psychiatric unit of Avicenne hospital in Paris which enables her to integrate the experiences she made during her fieldwork in Senegal. Armin Prinz desribes a culture bound syndrome that is endemic in Zaire and shows how indigenous concepts of disease can lead to misunderstandings between medical personnel and the people. Mohammad Shekari Yazdi reports on his field work with a traditional Iranian practitioner. And Alexander Weissenböck finally in the Visual Anthropology series presents his poster produced for the "Working Images", a meeting of visual anthropologists that was held in Lisbon this September (see also chapter "Congresses"). We are proud that we are now also present online. The address of our homepage is: www.univie.ac.at/ethnomedicine. We would be happy about your comments.
Again, we hope you enjoy this issue!

Ruth Kutalek

Pushing the Limits in the Inpatient Unit of Care

Hwiada Abu-Baker

Some occurrences in life appear to be insignificant, however when reconsidered seem to be potentially loaded with a momentous sense of contention in view of the unforgettable memories they create in ones' mind.

I attended an interview with the new students to be enrolled in the faculty of medicine at Ahfad University for Women in the Sudan and one of the questions asked to the young students who were about to start their education in medicine asked was: "Why do you choose medicine as a future career for your life?" Most responses ranged from: "Because of the good status of the medical occupation" to "Because of its capacity to cure human pains" or even to a response such as: "To be a doctor of medicine is a dignified job that enables one to help people".

These students' reflections lived with me for a while and resonated some time later, when I attended a conference in traditional medicine and clinical research in Egypt and I was very surprised to see how medical doctors were trying to establish a "relation of power" amongst each other by presenting papers on unique cases they were treating such as a schizophrenic child or twins born with only one head. I wondered whether those serving the medical field attending these conferences were really in need of so many examples of exceptional clinical symptoms for their every day practice of medicine. And how many cases of child-schizophrenia does a doctor treat in a year? This technique of "elite construction" by emphasizing the successful treatment of unique cases seemed to me a little bit queer in such a meeting. I think that it would have been more relevant if the "elite" had been encouraged by rewarding those who are able to deal more efficiently with common cold, influenza or any other common disease which the conference attendees face every day. With these impressions I went back to our newly enrolled young students in the School of Medicine who start with dreams of helping people and end up by running after recognition in the field of medicine!

All these thoughts in relation to biomedicine as a system of healing and its application in the unit of care crystallized when my four months old daughter grew sick and was treated as an inpatient for three months in a specialized clinic for children in Vienna/Austria. Through her tired eyes I started to realize some facts concerning the biomedical inpatient care system. Consequently, considering admission in a hospital as a unit of analysis, some major questions started to grow out of the blue.

Nevertheless, observations made here should not be generalized or considered a general rejection of "the inpatient hospital care". They are just reflections on how western biomedicine can be in some ways a thought provoking system.

Method

Participatory observation was the basic instrument for collecting data. I do not consider this process an ethnographic research, but "an action oriented" pre-research activity in which an outside researcher is trying to cooperate with the "social actors" working in the clinic to find compromise settlements to face the growing challenges and concurrently develop new concepts and understandings to guide future thinking. In this way limits can be pushed to reconsider measures of inpatients clinic admission. Observation as a methodological stance allowed me to attend and describe situations in different interaction processes without affecting the integrity of the setting.

In writing about the inpatient unit of care, I was motivated by two factors: first, the fact that Austria is accommodating more and more foreigners occupying different activities. Access to those people's knowledge and ideas reduces the possibility of conflict and increases the tendency of a cooperative spirit. As such, a peaceful relationship between the foreigners and the host country develops based on the integration of some of their immaterial cultural aspects into their everyday life need. Alternatively, introducing some cultural aspects may as well enrich the host country. The second fact is that the subject of health and healing really matters since it is directly related to human beings and their lives, and as such deserves research attention.

Three aspects are to be discussed in relation to the inpatient unit of care: first, the western biomedicine system does not address itself to some social problems capturing the public attention. Second, the tendency of western biomedicine to reduce the whole processes of health and illness into quantities such as kilograms and temperature degree.
Third, the emphasis of the health workers on their job performance rather than job efficiency.

In the following part I will try to illustrate through my own experience with the inpatient care system on how each of the above mentioned interventions has consequences for the patient, its implications for the caretaker and maybe possibilities of modification for the benefit of both the patient and the caretaker.

The System and the Underlying Social Problems

Gender as a Point of Departure

The inpatient unit where my child was admitted is to a great extent gender biased. On the communal photograph representing the staff members of the section, there are twenty photos of the doctors and the nurses of the department; and the twenty members are women. The whole institute seems to encourage the role of the mother (the woman) in relation to the upbringing and care taking of the child, not only in the mind of the child, but as well, in the mind of the father "the other partner". That appears even in the hospital language: the child nurse is always a "sister" not a male nurse. The impression I got as a caretaker is that: if the patient is a child, it is axiomatic that the person who is to take care of it is the woman/mother. For the staff members the mother, as a caretaker, has got the advantage: where the nurse distributes her attention among all patients instead of paying all attention to one child. In one episode, in the very rare cases when my child was visited by a male doctor, I consulted him concerning the health of the child and I was very astonished with the response I received: "Please ask doctor X about that, she is the boss here!"

The structure of the hospital itself does not encourage the accommodation of "a father" as a caretaker attending to his son or daughter patient. Some rooms contain two or three patients' beds, which are located very close to each other. Is the caretaker of one child the mother, it would be impossible for a Muslim father to attend the child in the same room, even if he wishes to do so. The section contains only one bathroom and water tap, and for some social norms and religions it is difficult to accommodate caretakers of different sexes. In a discourse with some female caretakers it was expressed that they were exhausted spending

days and nights attending to their children, however they always met with the rejecting manners of their male partners to play the role of the caretaker claiming that they had seen no man spending the night in hospital! According to my observations a significant figure of the child inpatients are foreigners. An important task would be to try to conduct a statistical survey on the different nationalities of child inpatient so as to identify possibilities of policy modifications according to the findings.

More dangerous is the effect of these processes on the child's cognitive development particularly in the times of suffering. These processes can be considered as a typical example of how culture and environment can reproduce social and cultural forms. At these young ages and in situations of suffering these developing human beings construct their unconscious inner image about their relation to the outside world, their unconscious sense of self-boundaries and their sense of gender. As many researchers have shown (Stern 1985; Winnicott 1989), unconscious fantasies and feelings are often communicated to the child, and the child itself creates the meaning of these communications. Thus, unconsciously, the system plays an important part in the process of the "reproduction of mothering".

This example of how a social environment regenerates the gender biased social and cultural forms has got its implications in relation to the caretakers as well. Once I noticed that among the women caretakers, the presence of a father becomes an aspect of "power relation" among the other women caretakers. Mothers like the presence of the father when he comes as a visitor to the child. Not only that but they even feel "different" and better than the others in the presence of the father. I was very astonished in the beginning, when at two different occasions and from two different mothers and perhaps in an envious manner, I was told in a whisper, when my husband was visiting the child: "Your husband is here!"

I grew very much interested in the aspect of gender as a point of departure. I then started to recognize that mothers usually liked to emphasize the role of the father as a helping being whenever he came to visit the child. Thus, they tried to organize some activities for him to show that he was "a great assistant" like sending him to bring milk for the child or to the hospital staff members to inquire about the child's health situation. One can even see them walking together "in front of the other women" to eat or drink something in the cafeteria, which is in a different part of this particular section.

Kilograms and Degrees

It is understandable that the temperature, the weight the child gains and the waste products such as urine or stool are indicators of the child's health when the child is under treatment. However, one finds that the issue is so emphasized that not only much of the medication aspect is reduced to these two components but as well these quantitative features became first a point of departure and stratification among different women in terms of the weight the child gains and speed he or she is recovering from fever. Even the mothers who were not communicating in the commonly used languages German or English, developed a sort of "instrumental working language" to act as a survival strategy for their everyday routine questions whether the child has had urine or stool at that particular day. In that respect the words "pepe" and "lolo" stand for urine and stool respectively, both among the hospital staff as well as the caretakers.

The quality - quantity dilemma also appears in the process of using technical methods of medication in the inpatient unit of care. Human weakness is tremendously manifested when people are suffering any kind of body break down. In response to such weaknesses the human body and the "social self" are two inseparable entities and should be treated accordingly. Yet, it appears that the vast increase in technical ability has not been accompanied by an adequate increase in social maturity in the hospital as a unit of care. To get deeper into this aspect it is useful to have a sharper focus on the system.

The System

The biomedical system in the children's clinic functions in relation to three main (assumably cooperative) components: the doctor, the nurse and the child's caretaker. The doctor represents the highest "medical status power".

(She) is the one who has the final say on releasing the patients or letting them continue to be under care in hospital. Historically, the physician exhibited many capacities whereby he was considered a philosopher a metaphysician and sage and as such he was referred to as a *hakim* or the wise man. In this particular system the role of the doctor becomes the role of the decision maker. (Her) decisions are consequently based on the documentation and realization of the different components of the system to the condition of the child under investigation. The decision is pronounced in the daily morning clinical examination she conducts. Despite the fact that the nurses are the ones who have immediate contact with the child, it is very difficult to get any information from them. The nurse responsible of the child rarely communicates with the child's caretaker. This process reflects that there is an order-obedience relationship from top to bottom of the hierarchy. I myself tried to raise different issues and my efforts entirely failed. The nurse gives the impression that she is strictly recommended not to release any information to the child's caretaker that can be counted against her, and loyalty to her career dictates silence.

Worth mentioning here is one episode when a nurse had registered that the temperature of my child was 38°c. The next morning the child's temperature dropped down to 36.7°c. The doctor asked me whether the child had taken any medicine to reduce the temperature. I responded negatively. She then suddenly asked me: "Who is the nurse who recorded this?" I responded that I did not know her. She then said: "Perhaps we should consider revising our system because I do not belief that a temperature of 38°c can drop down without any medication to 36°c". One fact I did not mention to the doctor concerned was that I was an eyewitness when the nurse measured the temperature in both cases, and I do not think that she had been mistaken in any of the two measurements. I found this incident to be queer and illogical, because if the doctor trusts the nurses to the extent that a large part of the decisions she takes concerning the patient's circumstances is based on the nurse's records then it is unnecessary to reflect her mistrust in the nurse's observation, at least in front of me. What I would suggest in these situations is that since the nurse is the one who is much of the time in contact with the child patient in hospital, thus, her role becomes more important even than the role of the casual contact of the doctor particularly in relations to the social contacts with the caretakers. As such to allow her some space of authority is necessary. It really reflects no sense of logic to ask a nurse a very general opinion on the child's condition and to get the response "Ask the doctor!"

One impression I get in relation to the patient in this particular incident is that, the western biomedicine system is so much attached to a very strict theories and methods of medication that it is very difficult to imagine patterns of medical phenomenon that can surface differently.

Job Performance versus Job Efficiency

Yes, it is generally believed that science based decisions should be based on universalistic logic; however, this does not mean that its outcomes and conclusions always have no other way than to be generalized. The hospital as an application of the biomedical system model ignores to draw upon the patient's psychological resources. Rather than simply manipulating the child's psychological structures in the fight against the disease during the treatment process, physical symptoms are central issues. Implicitly, it becomes recognizable that caretakers start to learn the lesson: the ticket for admission or non-admission of the child are the physical symptoms. The more severe the symptoms are the highest attention the child receives. Consequently, in response to the everyday question asked by the doctor: "How is the child today?", the child's caretaker describes merely the physical symptoms without seeing any new processes that might help the child to be better seen as a "normal individual" (such as new skills the child learns as it is in hospital, for example new activities like: to sit down or to stand up or even to walk). The child under treatment is continuously seen as a medical phenomenon till at one time through the nurse's records the doctor decides that it is to be released from hospital. Worth mentioning here is the child with whom my daughter was accommodated. The mother was a young Turkish lady who does not speak German or English. For three days the child was always sleeping when the doctor came to conduct her

routine examination. The doctor then, every time, read the records written down by the nurse and considered the child to be in need of further consideration. One day the doctor asked me to come and report the moment the child woke up. I did as she had asked and the moment the doctor examined the child she decided that it was in a very good health condition and should go home!

Another aspect is what I was told by a caretaker who said that her child was considered to require some gymnastics and physical therapy. At one point the physical therapist decided that the child needed to be transferred to the neurology department on the base that it did not sit down at the "scheduled time". The mother was very frustrated and she left the hospital that day deciding not to continue with the physical therapy. Two weeks later her child sat down in the very "normal way" children do as has been documented by the physical therapist herself some other time!

A Shortcoming of the biomedicine system is that since measures of health and illness are to a great extent dependant on items such as the temperature and weight the child gains, mistakes are unavoidable. The result is that I witnessed "two cases" that returned to hospital after being released, claiming that the child was still suffering when they went home. In this case, it is important to consider a "holistic approach" to health and illness by relating to the physical, psychological and mental health of the child, as well as by asking the caretaker.

Another problem of biomedical care is that there is no respect for the emotions of the caretaker when the child is treated. An incident that occurred to the son of an Egyptian lady is relevant to be mentioned in this respect. The lady said:

"One night while I was sleeping the nurse came and fed my child a bottle of about 120 ml. She then woke me up and reported the incident. I was very astonished because I knew that my child drunk no more than 80 ml, and particularly when he was sick, he decreased his feeding behavior to about half the normal doze. I just kept quiet as she wrote that down in her record and the moment she was away the child vomited most of the milk he was fed. The next morning the doctor was very astonished, thinking that I was not telling the truth when I told her that the child did not take the normal doze!"

A relevant incident to be mentioned here was when my child was considered to be strong enough to leave the hospital. At 11:00 a. m. the doctor told me that I could leave the hospital with the baby that same day, yet, I should wait till 2:00 p.m. for the report concerning the child situation and the general observation of the hospital. An hour latter, one nurse entered my room and directed me to leave the room and to wait with my child in the children's playroom for the report, because "another child will occupy the patients' room and the room should be cleaned". The episode was then followed up by myself pushing my child's bed all the way to the children's playroom and to come back several times to collect my scattered materials to evacuate the patients' room so as to wait for the prospected letter to be typed for nearly an hour! Other four mothers who were similarly instructed occupied the children's playroom. In a very inconvenient way I had then to dress my child and myself in the children's playroom.

If this incident reflects anything it is that patients are considered merely cases within the system. The moment the case was become an outpatient biomedicine loses interest in it. Consequently, a new case becomes more relevant and recommends better consideration. My child and the other four children were as well interesting cases and the fact they were decided to be outpatients does not mean in any way that they should not be tolerated in the patients' room till they leave the hospital. After all, one thing to be remembered was that we were waiting for the letter that had to be issued by the hospital's relevant administration and not because we had wanted to do so.

Power and distance relationships have always characterized the interaction between the biomedicine system and the patient's caretaker. However, in this particular situation when the sick role is played by a child whose caretaker is the mother, the doctor-caretaker relationship should be reconsidered. One fact that should not be forgotten is that the caretaker is an important component in the system of treatment; as such her opinion should be taken in consideration. In many cases the caretaker is

even not consulted pertaining to the child situation through the routine question: "How is your child today?" "One of the primary roles of health care is education", said Dr. Thatcher in the opening of the Center of Applied Reproductive Science at the Johnson City medical Center in America. "Patients must know the options and the rationales behind them" (World Report 1997). To the contrary, the western biomedicine system many times does regard these principles. As one Turkish mother claimed: „Every morning they take my child for blood examination. Yesterday, while I was sleeping I heard my child crying and I woke up to find that the nurse was taking the child for blood examination. That has been the case for several days now. I do not know even what did they find in my child's blood?"

For me, even though some mothers are considered by the staff as "being little educated", yet these mothers are very much concerned of their children's situation and the medication process. For them any medical intervention with the child is interesting and they want to know about its results. In the end, all are concerned with the benefit of the child. The need of an anthropologist is very important in such situation, although it is recognizable that there is a child social worker, and a psychologist that works with the child caretaker, one misses the role of the cultural anthropologist who can work with the child's caretaker in such situations.

If one can say a word to the biomedicine agents: Please do not lose sight of the fact that you went into medicine "to help people".

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Working with Immigrants in a Paris Suburb – from Ethnomedicine to Transcultural Psychiatry

Felicia Heidenreich

When I was in Senegal doing ethnomedical fieldwork, I had absolutely no idea of what I would be doing after the end of this research project. Ndiom Faye, the healer I worked with, knew before I did. Once we visited his older brother Boukar Faye and he explained why he had accepted me as an observer:

"She is a doctor and she is only learning. She wants us to enlarge her knowledge so she can rely on it when she goes back. Our Seereer people are over there and they have to be cared for. (…) If she does her doctoring, wherever she is, even if it is in her country, I will ask my *pangool* (power principles related to ancestral spirits or inhabiting certain places) for it, they will help her and she will never be wrong. Everything she will do, will be complete; I can do that. (…) Of all the doctors she will be the best, she will work with injections and she will work with roots, everything, she will work with all this, if she looks for it."

At the time I did not pay very much attention to these words, I thought this was a good explanation that helped the healer, his family and friends accept my presence and feel important at the same time. Looking at these words now, more than two years later, I feel that they were a sort of prophecy I am fulfilling with my present work.

Through the description of my own professional course and work, this text will give an answer to the question of how ethnomedical research can be of relevance in clinical work with migrants. After a very classical medical training, ethnomedical research confronted me with a different way of thinking about the body, its functioning, diseases and misfortune. I had to take a step back, forget about anatomy and physiology, about pathological logic and microbiological reasoning, in order to approach traditional concepts concerning the body and disease. Knowledge about medical anthropology was of

some help, but it would have been dangerous to rely on prefabricated models only. My findings on Seereer traditional medicine and my feelings during fieldwork are described elsewhere (Heidenreich 1998, 2000abc, 2001) and I won't get back to that.

For more than one year now, I have been working in Bobigny at the Avicenne hospital in the psychiatric unit of Professor Marie Rose Moro. Bobigny is a working-class suburb of Paris with a very high ratio of immigrants mostly from the former French colonies in sub-Saharan Africa and the Maghreb as well as refugees from all over the world. Unemployment and violence are quite common and adequate health care structures are rare. Within the psychiatric outpatient clinic, Moro has created a unique approach known as "ethnopsychiatry" trying to accommodate special needs of immigrant patients (Moro 1994, 1998). Underlying this special setting is a whole theoretical framework that has to be explained before going on in the description of our practical work. This work is based on Georges Devereux's complementarism (1970) which calls for an obligatory but never simultaneous use of several disciplines, especially psychoanalysis and anthropology, but also religion, history, linguistics etc. in describing and analyzing a given situation. The troubles a patient presents have to be explained by means of several modes making sense for him and for his caregivers. Moro distinguishes three levels of comprehension that are necessarily linked: The ontological level explains who the person is according to the cultural models and the concept of how one comes to life. The etiological level deals with the discourse around the causation of the suffering, well documented in medical anthropology and the subject of many analyses. Both former levels determine a third one, the logic of traditional therapeutic approaches.

What renders work across cultural barriers possible is the paradigm of psychic universality that stipulates a universal functioning concerning psychological mechanisms and contents. Even if the expression of suffering is culturally coded, it can be understood and cared for. Therapy is intra-cultural if patient and therapist are of the same cultural background, intercultural if they are from different cultural backgrounds. Ethnopsychiatry can be called transcultural because it relies on principles common to all cultures but takes into account the differences and works with the cultural elements explicitly. These basic theoretical ideas will be illustrated through a description of the therapeutic framework and the way we work with immigrant patients, as well as two case studies of families we have been following for some time.

Patients are referred to our clinic by other doctors, psychologists or social workers who have the feeling that the cultural elements of the suffering are on the forefront of the symptoms and they feel blocked by the "unknown and strange" elements they don't know to handle. Patients are invited to come accompanied by all family members who want to participate in the process of elaboration. The therapeutic group consists of about a dozen co-therapists and students. Most of them are either migrants themselves or have an experience of "decentrage", of living in a culture different from their own and of understanding the coherence of different systems of thinking not only in theory but also in daily life. They are psychologists or psychiatrists of psychoanalytical orientation. There will always be an interpreter allowing for an expression in the mother tongue even for patients who have a good command of French, as concepts very close to cultural representations are much easier to express in one's own language. The role of the interpreter is crucial also as a mediator and specialist concerning certain anthropological facts; interpreters have a special training in order to meet the expectations of this role.

If the family is accompanied by children, they are permitted to play or draw in the center of the circle of all participants. Only the main therapist addresses direct questions to the patient or family members. He or she is the director of the session and asks the other therapists to intervene on certain issues, interpreting dreams, giving images or metaphors related to the patient's story, counting tales or giving examples from cultural representations they know well. He might reformulate or filter these interventions. This allows for a protection of the patients, who will have the feeling of being carried by the group which re-creates in a symbolic way the social group in which the patients grew up in their respective country of

origin and which is lacking in the host country. Among the co-therapists they will find figures of identification they can rely on. This group "envelope" is essential for the elaboration of a story of sense that is culturally acceptable; it enables the patient to re-establish the barrier between a psychological interior and exterior which is often times hurt in the process of migration. On this basis, the question of the sense of suffering can be tackled and therapeutic propositions might be engaged. There are never attempts to perform rituals in the group context, but the patient and his family are invited to do things they know or ask their close family members or friends on how to do something significant. The group never imposes one point of view, but tries to carry the family during this process of elaboration during which a number of hypotheses will be examined. Only some will be kept as valid and pertinent. This process seems very logical and simple, but would not work without its theoretical background and the practical group framework. The group has a very important function carrying the family and symbolically re-creating the structure holding this sense everybody needs so badly when facing disease and misfortune.

A clinical case study will illustrate this process which sometimes takes quite some time; the group sessions take place only once every one or two months and the patients are often involved in an individual psychotherapeutic process elsewhere or with one of the co-therapists.

Kamel is 5 years old and had been diagnosed with autism. His parents came from Algeria 20 years ago; all their children were born in France. Kamel is the last one, his older brother and sister are more than 10 years older. For the first few group meetings, his mother treats him like an object, and there is visibly no positive interaction between this mother and her child. The group sessions allow for the construction of a family narrative, including the generations above and the story of the parents' migration. On the basis of this narrative, first questions and hypothesis are expressed: Who is Kamel? What is he made of? Where does he come from? Attempts to answer these ontological questions might include the idea of the sleeping child ("L'Enfant endormi", a widely spread concept in the Maghreb cultures), or the resemblance with a grandfather who died before Kamel's birth and for whom his father had not been able to meet his obligations concerning the funeral ritual. The family history might also lead one to evoke the idea of a special gift in this child inherited from an ancestor. A very important issue is the name of the child, where it comes from, and what it means. What is happening to Kamel? Where does the misfortune come from? How can his disease be explained? Why is he touched? The etiological questions might be answered through concepts of possession; Kamel might be touched or inhabited by spirits, especially djinns, or through ideas of witchcraft and sorcery, expressed through the "bad eye". Infractions concerning family taboos and rules (e.g. marriage, dowry, funerals or behavior during pregnancy) might also be at the origin of the disease.

A common statement is a lack of protections for this child. This leads to the therapeutic propositions that may be made asking to make up for what has been omitted. Other rituals have a repairing function concerning the taboos and rules infringed.

By now, Kamel and his mother have come to develop their very special interaction which gives evidence of their relation based on the mother's recognition of her son. Her son's strange behavior has got a certain sense for her, it can be understood and she can act accordingly. This show in the behavior of Kamel within the group, he chooses to play with some of the co-therapists and his interactions are more and more like attempts to communicate. The father still struggles with his role as father and husband and will need some more time to work out his position within the family and moreover concerning his son's disease. Only then might he be able to get out of his very depressive mood and see beyond the symptoms of his son.

Every family we meet has a very unique story to tell, there is not one way of approaching the problems they face and want to share with us. It is with open-minded attitude and caring compassion that we encounter these patients and their families in order to work with them instead of about them.

The initial question of this text, on how ethnomedical research can be of relevance in clinical

work with migrants, clearly finds its response in the above descriptions. In order to be able as a therapist to carry patients from cultures different from our own, we need to fulfill two main criteria: we need to understand other ways of explaining disease and misfortune as in themselves coherent and logical, and we have to take a certain critical distance from our own origins, based on the experience of "decentrage". Medical anthropology is then a very valuable source of information in trying to understand certain ideas of causality and therapy. Across ethnographic monographies, we can find recurring concepts and explanatory models that help us gain the confidence of our patients when we give them the feeling that we do not reject other ideas of giving sense. In that way, we do not need to have an anthropologist for every patient, but the anthropological knowledge of the group creates an atmosphere where patients dare to talk about their ideas. It is across these recurring themes in causality and therapy that the notion of the psychic universality takes on its full importance.

Thus, work with immigrants from all over the world is a constant challenge demanding attention, compassion and understanding. One of the very important points in this kind of work is the constant analysis of the cultural counter-transference, a psychoanalytical concept that has been adapted to the transcultural situation. In our attitude and relation with our patients, elements of our personal history play an important role, but so does our position on our own culture and those of our patients. We have to be aware of the negative interference caused by different positions concerning, for example the role of women, and what we think would be good or bad for them.

Ethnopsychiatry is a very new field of work and research. It is a work in progress and the approach of M.R. Moro is one that has proven to be functional. Without my research experience in ethnomedicine I would have never thought of working in this field, and it is the respect of my patients for my knowledge about and my interest for the "things from far away" that makes me feel I am at the right place where I can link research with clinical work.

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Kaza basolo – A Culture-Bound Syndrome among the Azande of Northeast-Congo

Armin Prinz

Abstract

Kaza basolo is caused by members of a secret society of hunters and fishermen in the Uele area near Dungu and Niangara. This society is said to need parts of human genitals for magical purposes. These people carry around their waist a cord with a small sachet containing certain materials such as leafs and bark from trees with supposed supernatural properties. When shaking hands with the victim their penis or clitoris "wanders" along the arms into this sachet. Back home the *boro basolo*, as the members of this society are called, burns this material down to a black powder, which he smears over the hunting arms or the fishnets in order to obtain more animals. In the meantime the victims begin to suffer due to the magical robbery of their genitals. They are forced to make efforts to regain them before they are carbonized. In panic they are consulting specialized traditional healers called *boro ngua*, who start to make certain procedures like the magic whistle *kula* against the malefactor. If this is not effective the tribal court could be appealed to force the accused *boro basolo* to return the genital. In case also this effort fails, the victim is said to suffer seriously with fatal consequences.

In some parts of Zande-land this culture-bound syndrome is already epidemic and an enormous sanitary problem for the population. Traditional healers start to do "vaccinations" by scarifications, in which protective magical substances against the *kaza basolo* are rubbed in.

Introduction

To anthropologists the Azande became famous through the excellent book "Oracles, Witchcraft, and Magic among the Azande" by Sir Edward Evans-Pritchard (1937). As far as beliefs in causes and social background for illnesses are concerned the presented ethnographic data, as well as the theoretical value of this work, is still surprisingly accurate as researchers in this area will observe. For the understanding of these phenomena the knowledge of certain belief-patterns is necessary which already Evans-Pritchard has described in its basic outline - the bicausality of illness.

According to Azande belief misfortune in general and illness in particular is always caused by two factors which both have to be present at the same time. The first factor is a natural one, for instance infections, hunger, cold, bad foodstuff etc. The second one is witchcraft or magic. For example: Someone walks through the bush and breaks his leg. The natural reason could be that he stepped into the hole of an aardvark *(Orycteropus afer)*. But the victim will also ask himself what was the reason for my inattention. Who wanted to do me bad in blurring my vision and why? And there are only two possibilities for this disturbed condition – witchcraft or magic evoked by an envious neighbor, a jealous woman or an evil rival.

It depends on the social condition of the victim which of the two causes, the natural or the supernatural, is taken more seriously. If the person has no problems in his social environment he will know that there is probably somebody who wanted to do him bad but he feels himself strong enough to resist this attack without any further measures. He will concentrate on the traditional surgical treatment of the fracture alone and will not be much interested in investigations against witches or sorcerers in his social surrounding. If the victim is in a bad social condition the treatment of the fracture will be secondary to him, but he will do everything in his might to discover the evildoer who has provoked witchcraft or magic against him.

We can state that witchcraft and magic among the Azande are not only to be explained in a supernatural sense, as Evans-Pritchard has done it, but as a sign of social disturbance of the individual in his community. This distur-

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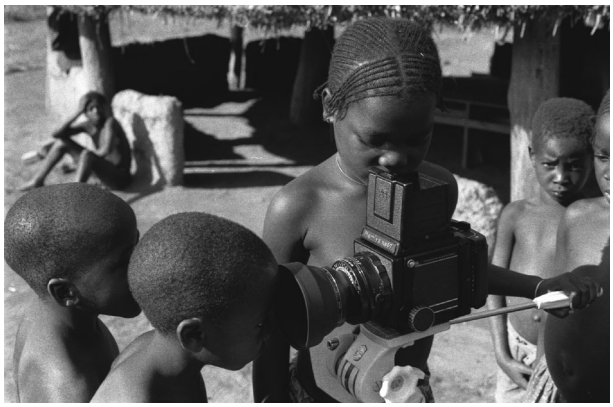


Our logo for this series: Azande children inspecting the camera of a visual anthropologist.
Photograph: Manfred Kremser

Contributions to Visual Anthropology

Shamanism and Witchcraft in the Paintings of M. Moke

Alexander Weissenböck

The work of Congolese artist Moke is recognized throughout the world of art, since Pierre Haffner discovered it in the 1970s when working for the Centre Culturel Français in Kinshasa. Moke is famous; some of his paintings form part of the collection of the Modern Art Museum in New York. His work focuses on the social conditions of his country and shows scenes of everyday life. Some of his paintings also illustrate scenes of traditional medical treatment. There are three paintings in our collection that are concerned with witchcraft, traditional medical treatment and shamanism. They demonstrate how Moke visualizes and translates Congolese beliefs in witchcraft, possession and other supernatural powers, which are only partly expressible in words. They also show how he uses African and Western symbols to make the content of his art understandable to both cultures. The paintings illustrate how much witchcraft, traditional medical treatment and shamanism are still alive in the African world. The first painting (Fig. 1) shows a traditional healer and his patients. The healer is treating various diseases. The woman on the far left is suffering from gastritis. The one standing behind her is suffering from irregular blood pressure caused by sorcery. She is being treated with calabash-made vessels that are held to her temples. The different people with colored faces are suffering from mental disorders. The woman lying on the floor cannot find a husband despite her wealth and corpulence. The healer has diagnosed spirit possession and is rubbing her with a chicken to free her of the demon. This demon is already lying on the floor and the healer is sitting on top of it. Signs of the healer's profession are to be seen in the form of horns on his forehead, the leopard fur and the red cross that is painted on his head, shoulders and back. The second picture (Fig. 2) shows a scene in which some soldiers are attempting to rape women. The latter are defending themselves by means of sorcery. One woman bears the long teeth of a demon while the soldier trying to catch her is growing big ears as a first sign of the effect of the woman's sorcery. Another woman is wearing a large padlock on her pants to symbolize her resistance to the attackers. The third painting (Fig. 3) depicts a healer with his helping spirit. He is portrayed with different signs that are symbols of sorcery, such as the spots, the claws and the fang of a leopard. Like a sorcerer, the healer can also transform himself into a leopard. He has to have the ability of a sorcerer to be able to recognize and heal sicknesses caused by sorcery. For this reason traditional healers are feared and quite often suspected of practicing sorcery themselves.

(For the figures see next page.)

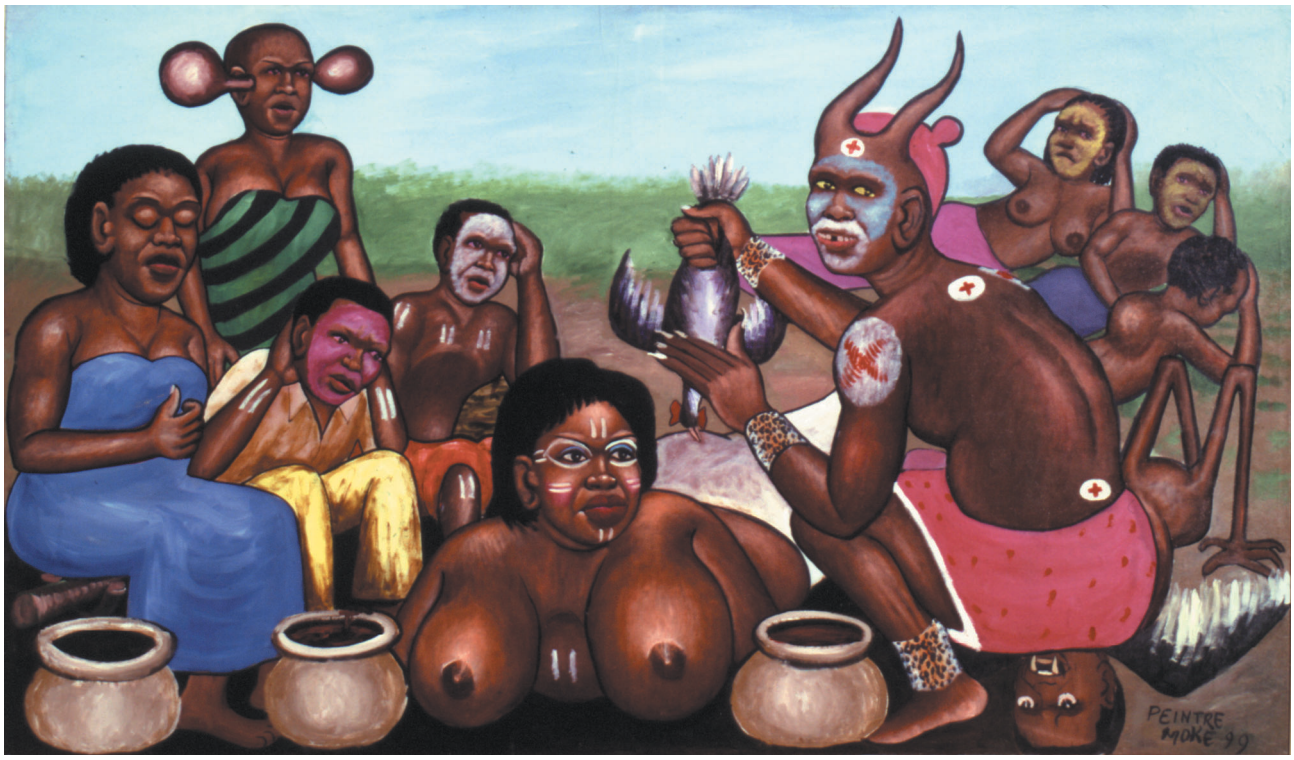


Fig. 1: Nganga Kisi: Guérisseur

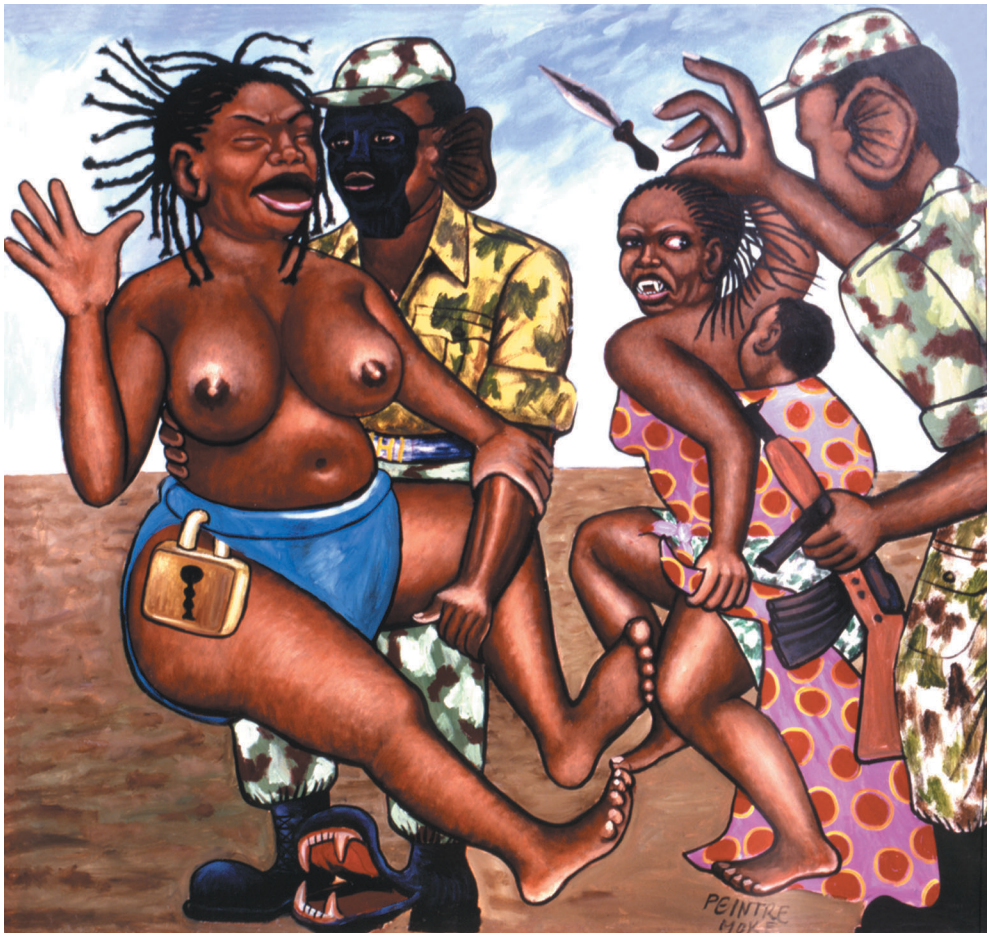
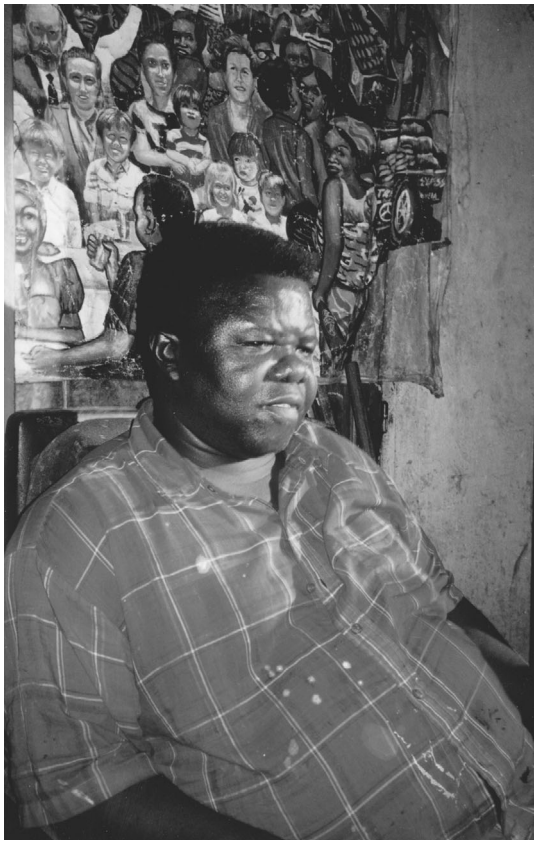


Fig. 2: Nakomi Nganga Kisi: Je suis devenu Guérisseur

Fig. 3: Ba Rebelles bazolinga basi na makase:
Les rebelles veulent violer les femmes



Moke in his studio, July 1999

As we have just learned M. Moke died of a heart attack on September 24, 2001 in Kinshasa. Moke was born in 1950 in Ibe, Belgium Congo (now Democratic Republic of Congo) and started painting in 1963. In the seventies he was discovered by the late Pierre Haffner who became his promoter. In 1978 he had his first exhibition in Kinshasa, 1979 Berlin (horizonte) followed. 1983 he presented his work at the Goethe Institute in Kinshasa, 1991 in Paris (n.o.m.a.d.e.) and New York (Museum for African Arts), 1993 in Cologne, 1994 again in Paris and in Liverpool (Tate Gallery) and 1996 in The Netherlands (Staadsgalerij Heerlen). Last year we organized an exhibition at the Vienna International Airport on painters in Kinshasa which included Mokes' work as one of its highlights.

Kaza basolo – A Culture-Bound Syndrome among the Azande of Northeast-Congo
continued from page 12

bance can be so strong that the original natural cause starts to be completely irrelevant and the supernatural one becomes predominant. If magical practices are conducted by secret societies the members of which are known to be very powerful, socially well-established persons are in fear and panic easily, too.

Secret societies are very common among the Azande. They are founded for political reasons but also for the economic benefit of their members. Their members are practicing special magical rituals in order to enhance the feeling of social unity. These societies are often subject to a frequent change and of only local importance. Sometimes only a few decades later nothing is known about the existence of a society that was described as important by early anthropologists. Evans-Pritchard in an article reported about an, at his time, immensely important society, called the *mani* society, which was politically very important as resistance movement against chiefs who collaborated with the colonial authorities (Evans-Pritchard 1931). But nowadays nearly nobody can remember it anymore.

The syndrome *Kaza basolo*

August 28th 1983, in Dungu, Northeast-Congo (former Zaire), in the tribal area of the Azande: Nako, a young woman comes to a small dispensary together with her mother. She is very weak and has to be supported by the old woman. With a flood of words the latter explains the complaints of her daughter to the European doctor. For a couple of weeks she has been suffering from a *kaza basolo*, an illness, which is caused by a bad person who has stolen her clitoris (*kaza* is illness, *basolo* means to scrape something away). Now she is in danger to lose her life. Her whole belly is hurting and she is in risk to bleed to death. She is not able to walk alone any more and in an upright position she is nearly fainting. The doctor examines the patient. The belly is soft, only a small, abscess-like formation is to be seen at hand's breadth left to the navel. The genital area, besides a menstruation-like bleeding, is without noticeable alteration. The doctor tries to explain them that there are no pathological findings, especially the clitoris is absolutely normal, but all in vain. Undiscerning to his opinion, both of them persist on the story of the stolen clitoris. To calm them down he orders to do the in bush clinics usual laboratory examinations: blood-smear, blood count, hemoglobin, faeces and urine for parasites. The results were negative besides a considerable anemia, which cannot be explained by the discovered low and for this area common infection with hookworms in the stool.

The pathogenesis of *Kaza basolo*

Without sufficient knowledge on traditional beliefs concerning etiology and symptomatology of this *kaza basolo* the Western doctor easily tends to be irritated by such a "superstitious nonsense" neglecting the complaints of the patient. But for the Azande it has a strong reality in day to day life. They refer to *basolo* in such a realistic way that even Christian missionaries believe, Azande are practicing real clitoridectomy.

If one is willing to understand the background of this illness he would learn that among the Azande there exists a secret society of hunters and fishermen called *aboro basolo*. To have better success in hunting they conduct forbidden magical exercises/practices for which, according to Azande conception, they need a clitoris. In order to earn much money by selling the meat the members of this secret society do not hesitate to risk the health and the life of their victims.

On their belt they wear a small leather bag that contains magical plants. If a member of this society offers a woman his hand, her clitoris "moves" over the arms into the bag. Back at home the wrongdoer carbonizes its contents together with this imagery clitoris, mixes it with different magical oils and smears the substance on his hunting weapons – now he will make his fortune in hunting. The woman who believes to be robbed of her clitoris reacts with panic. First she has to try to get it back. She can even appeal to the tribal court to sue the hunter. If she is not successful in forcing him to give back the small bag or if the content was carbonized already, the illness progresses. Her menstruation will be disturbed and other bodily and psychic complaints, like pain in the belly, the

articulations and muscles, certain kinds of dermatitis, restlessness, panic-attacks and social disorders are sure to appear.

In rare cases also men are said to be victim of *basolo*. They believe that their penis is stolen and start to have the same sanitary problems as the sick women. Although the penis is actually still present for the victim it has vanished. However, the penis is not very desired for the preparation of this magical substance because the sorcerer is afraid that he will only catch "strong" animals like leopards and lions in his hunting-nets which are dangerous for him and without economical value.

In the figures a young Zande Aly has drawn how the removing of the penis by a basolo sorcerer is thought to work. As we have stated men are very rarely affected by this magic. We argue that the traditional shyness even to mention the name for the genital of the opposite sex was the reason for this young Zande to draw the theft only of the male organ.

Fig. 1: "It happens during greeting that this sorcerer removes his genital."

A third possibility for the cause of *basolo*, though the feature is slightly different, is due to the consumption of meat from animals, hunted by means of this kind of magic. In this case no genital bleeding occurs but severe belly pain, vomiting and bloody diarrhea. People believe that this meat is decomposing very quickly and is not suitable for conservation through smoking.

According to the bicausality of illness among the Azande, the people in the case of *basolo* are of course aware that there must be also a natural reason for the outbreak of the illness but the fear of being infected by this magic is so overwhelming that the natural cause is hardly of any importance.

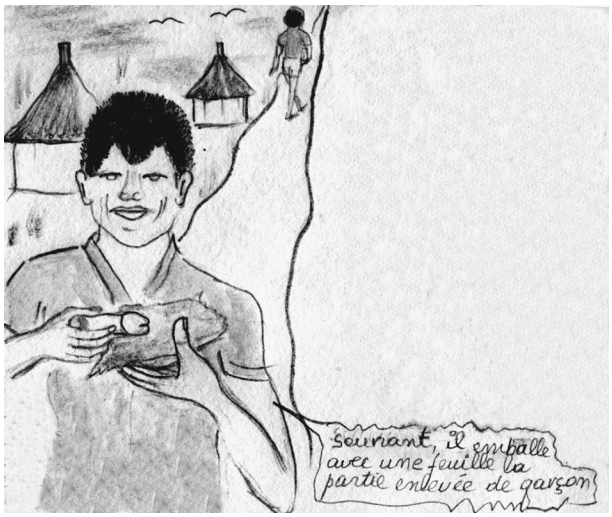


Fig. 2: "Smiling he wraps the removed part from this boy into a leaf."

The treatment of *Kaza basolo*

If a woman believes that she was harmed by *basolo* her first activity is to try to get back the stolen genital from the sorcerer before he is able to burn it. Hereto she starts to get the help of her relatives in order to examine her social environment for suspected persons. This is done not only by normal investigations but also through the means of oracles. The oracles among the Azande have a hierarchic order which depend on the kind of oracle and the social status of the oracle-operator. The highest-ranking oracle is the famous poison oracle *benge*, which is also used as an ordeal at the tribal court. If the minor oracles, which are conducted by old family members of the victim,

Fig. 3: "Arrived at home he is not wasting time to burn this removed part in order to produce his terrible medicine for the hunt."

Fig. 4: "After the sorcerer has removed the penis of the boy, after some meters, he starts to suffer very much."

have detected a suspicious person who refuses to confess his guilt, she will go to the oracle-operator of the tribal court to confirm the first finding through the poison oracle. If this is also positive the detected sorcerer has to accept his guilt and is forced by the society to give back the stolen organ. Additionally he is punished with prison.

Not always is the solution of the problem solved that easy. In most cases time is not sufficient to detect the evildoer because after the theft of the genital he is running home quickly in order to burn it. Now only very special healers, the *abinza basolo*, are able to treat the symptoms of the illness. But since the genital has been already destroyed, no treatment can cure the victim completely. Because of this defect she is always in danger to die suddenly. This involves a permanent handicap that deprives the woman of a normal day to day life.

The prophylaxis of *Kaza basolo*

As this syndrome in some areas of Zande-Land, especially around the town of Dungu, is very frequent and involves the greater part of society, a general hysterical reaction is only logical. As a problematic kind of avoidance of this syndrome some people already restrain from shaking hands thus evoking social isolation, for this habit is an important part of Zande communication.

A specific prophylaxis is executed by some healers, who in large-scale programs are, similar to Western type campaigns, traditionally vaccinating the population. Special medically used wild onions are carbonized, powdered and mixed with peanut oil. This paste is rubbed into incisions made with a razor blade in the place between thumb and forefinger. After this operation the healer wraps an armband made of savanna grass around the wrist, takes in deep

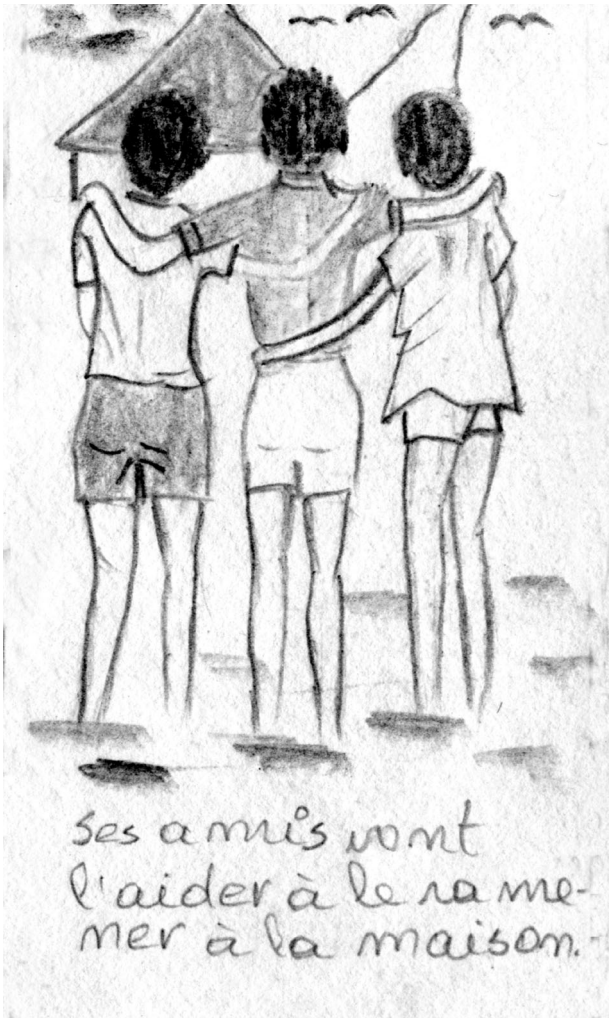


Fig. 5: "His friends have to help him return to his home."

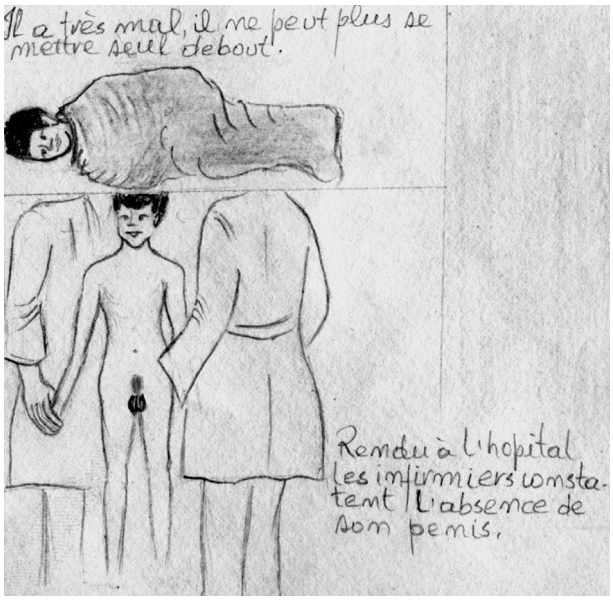


Fig. 6: "He feels very bad, he is not able to get up alone." "Arrived in the hospital the male nurses are stating the absence of his penis."

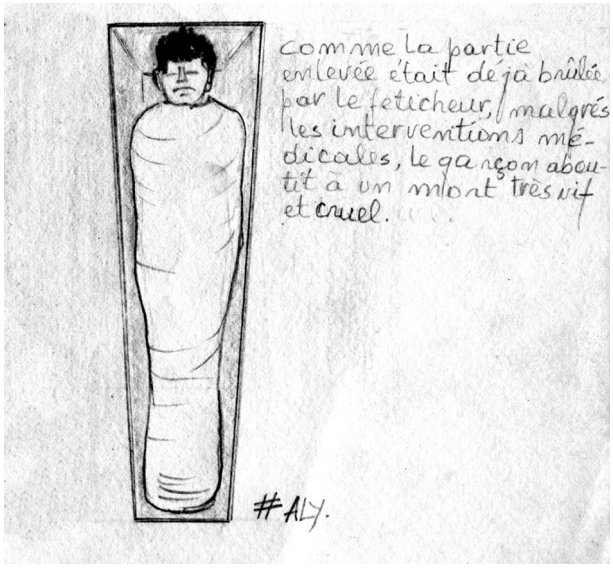


Fig. 7: "Because the removed part was already burnt by the sorcerer and in spite of medical interventions the boy ends his life in a very drastic and cruel death."

concentration both hands of the patient into his and appeals to his ancestors to defend his protégé against the *aboro basolo*.

Discussion

Apart from interpretations that this phenomenon is a manifestation of gender problems the syndrome *basolo* above all shows one thing: the somatization of conflicts in foreign societies can only be understood if their social and cultural backgrounds are sufficiently known. For these society-specific illnesses the term "Culture-Bound-Syndrome" was established. According to the ethnopsychatric taxonomy of CBS (Simons/Hughes1985) *basolo* can be subsumed to the so-called Genital Retraction Taxons. The basic of this taxon is the fear of loosing ones sexuality, a fear that is universal to humans but is manifested in different forms. The main syndrome of this taxon in the literature is the Penis Retraction Syndrome "koro" from East Asia and Africa (Ilechukwu 1992, Jilek 1986). This was the reason that recently the existence of CBS was controversially discussed by ethnopsychiatrists. Some scientists, though, define these disturbances as cross-c ultural because the basics of these syndromes are common neurophysiologic phenomena.

Seen from a wider perspective it is not so much relevant if these syndromes are culture-bound or cross-cultural. The fact is that their feature is culturally so specific that their control and treatment is only able by means of the corresponding traditional medicine. For the patients who are suffering from these syndromes the theoretical discussion of the scientists is of no importance. To them syndromes like *basolo* are a reality, influencing their social, economic and cultural life and they have the right that these problems are accepted as what they are to them: enormous disturbances of their health conditions.

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Hejamat in Contemporary Iran – A Brief Report of my Field Study

Mohammad Shekari Yazdi

During one year of field study on traditional Islamic medicine in Tehran-Iran in 2000/2001, I encountered different types of traditional medicine men who regarded their practice as Islamic medicine. For example, there are manyherbal medicine shops in Iran that provide different types of herbal medicine, mostly local herbs but also some imported from China and India. Their herbal prescriptions are mostly based on the Canon book of Avicenna. Of course there are many sayings reported from the Shiite's Imams about the different herbs that are used by these healers.

Another group of Islamic healers are religious-spiritual healers. One of the most famous is Dr. Nabati who treats different diseases with a piece of *nabat* (a kind of crystallized sugar) on which he casts a spell. Because black magic is forbidden in Islam, some healers do counter-magic to neutralize an evildoer act (e.g. a sickness) or prescribe talismans and writings to be used against diseases.

The most widespread form of the so-called Islamic medicine is *hejamat* (a kind of cupping). Cupping is a very old tradition that is older than Islam and can be found all over the world. *Hejamat* or Islamic cupping has its specific characteristics that are mostly based on the prophet Mohammed and Imam sayings (i.e. Ancient Arabic and Persian traditions).

Hejamat means "to make voluminous", to give more space for one's mind and body to function. Shiite medicine is based on four humors; the most important of them are blood and bile. On the basis of Shiite tradition *hejamat* is useful for prevention of all kinds of diseases and for the treatment of imbalance of the blood. *Hejamat* in Shiism, according to my observation, is divided into seven types:

1 *H. Khoshk* (dry cupping): This type is especially good for bile imbalance; the other seven types which are wet cuppings, are prescribed for blood imbalance
2 *H. Aam* (general cupping) between the shoulders is done before carrying out other types of *Hejamat*
3 *H. Nejatbakhsh* (life-saving cupping) on the vertex, especially for headaches and psychiatric disorders
4 *H. Rahanandeh* (relieving cupping) on the lower back, especially for musculo-skeletal disorders
5 *H. Noghreh* (neck nape cupping) on the back of the neck prescribed only for infants and children
6 *H. Saghain* (calve cupping) on the calves prescribed especially for pruritis and skin exanthemas
7 *H. Mozeii* (regional cupping) on other places with a local effect

On the basis of my observation the most common type of *hejamat* was the general type.

There are different opinions about the best time for *hejamat*. Wednesday, for example is a very bad day for *Hejamat*; in contrast Monday is a very good day. The first days of the moon calendar are also good, except the first day of Ramadan (fasting month) but there is no absolute *hejamat* contraindication.

As a general rule, *hejamat* is done monthly from the age of four months onwards. There is a very famous saying that when Prophet Mohammed went to the seventh sky all the angels said him: "Ya Mohammed do *hejamat* and order your followers to do so." Nowadays the time interval of *hejamat* is determined in relation to one's age. For example, if a person is 20 years old, he or she should do *hejamat* every two months, if he or she is thirty years old, every three months and so on.

Method of *Hejamat*

There are three types of *hejamat* cups. One is 75 ml, the other 100 ml and the third is 150 ml. On the basis of patient age and the body location, one of the above-mentioned cups is chosen

and connected to an electric or mechanical suction. After one minute a round elevated and congested piece of skin develops that is lacerated by a surgical blade in wet cupping. Because Prophet Mohammed received *hejamat* order in the seventh sky, the *Hajam* (the person who does *hejamat*) makes seven lacerations, four on the upper semicircle of the congested skin and three on the lower semicircle. When the cup is half filled, it is emptied and the procedure is repeated three times. During this procedure the patient reads a special holy verse that is hung on the wall in front of him or her. In this verse he or she wants Allah to make him or her healthy.

HRII (*Hejamat* Research Institute of Iran)

In Iran there is a revival of this kind of practice. Till some years ago *hejamat* was done by non-physicians and was totally abandoned by the government. However, due to the efforts of *Hajams* and HRII, it has been recognized, albeit non-officially, by the Ministry of Health. At the same time, *Hajams* have been urged to work under the supervision of a physician. HRII conducts different research projects involving *hejamat* and has a diploma course of *hejamat* for medical doctors. Presently HRII has about 500 MD members who regularly report on the results of *hejamat* treatment. Up to now, HRII has published two monographs, one regarding *hejamat* in different Hadiths (holy sayings of Imams and prophet) and the other regarding *hejamat* in the writings of Islamic scholars. HRII has published some research articles regarding *hejamat*. Among them can be mentioned the comparison of the blood composition of venous blood and the blood that oozes out during the *hejamat* process. In my interview with Mr. Kheirandish, the head of HRII, he said that they had very good success reports of this kind of treatment. He mentioned excellent results of *hejamat* in dermatologic diseases like psoriasis and eczema and said that it works better than routine allergic desensitization. He said that all types of migraines could be cured 100% with five treatments of *hejamat*. He also mentioned that they had a case of pemphigus that was treated by *hejamat*. (We know that pemphigus is not treatable, just controllable.) Finally he said that the main effect of *hejamat* is on the immune system and it can be used as an excellent device for autoimmune and other immunity disorders. Nowadays research on vitiligo is being carried out in the HRII with very good preliminary results.

Ghasem Parvaz, a traditional Hajjam in Iran

Hejamat was a a major form of treatment for hundreds of years in Iran, but after the introduction of Western biomedicine it was forgotten and prohibited by the government. Ghasem Parvaz was one who was engaged in the revival of this tradition and who suffered as a result.

Ghasem Parvaz is a famous name in the field of *hejamat* for Iranian Hajjams. He is so famous that some physicians who also do *hejamat* mention his name as a supervisor. Ghasem Parvaz is a 52 year old male with a long beard and hair and a long dress which he wears especially at home. About 20 years ago he developed laryngeal carcinoma. During his stay in the United States, he went to different doctors without any significant results. On his return to Iran he saw a man one night in a mosque who advised him to do *hejamat*. Till that time he did not know anything about *hejamat*. He asked his wife about it and she said that in the past there was a man who practised it in her village in the north of Iran. They therefore went there and they found an old Hajjam who was doing *hejamat* with a horn. Parvaz did *hejamat* and as he said all of his laryngeal symptoms healed very fast afterwards. After this event, he began to fast to thank Allah. Since then he started to do *hejamat* and became a *Salavati Hajam* (Salavati means a person who does his or her work free of charge and only asks the person who has benefited from his or her work, to say

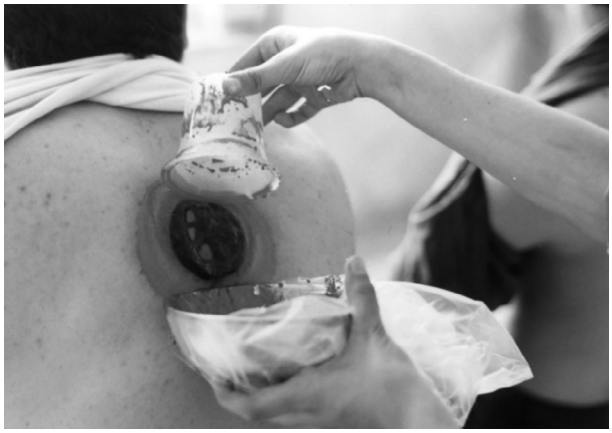

Fig. 1: Cleaning the back after cupping

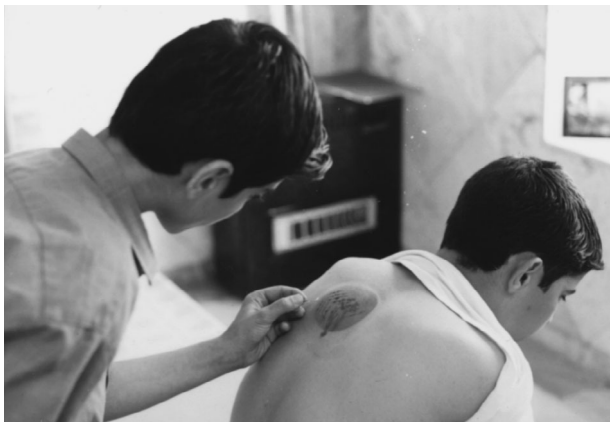

Fig. 2: The Hajam's son doing scarifications after cupping

peace upon Mohammed and his lineage i.e. Salavat). Therefore Parvaz is regarded as the father of *salavati hejamat*. He started to do *hejamat* alone, then sometimes with the support of some physicians. Meanwhile he has been brought to court repeatedly for his interference in the medical area in which he is not regarded as eligible. Three years ago, when he was in his *hejamat* office, some officers came to lock his office due to his interference with the medical issues. He had a fight with them and injured one of them. As a result he was put to jail and it was there that he saw a light which ordered him to fast for 40 days, i.e. to eat and drink nothing except water before sunrise and after evening. During fasting he found freedom and after 40 days of water fasting he experienced a kind of rebirth. Then he stayed mostly at home and his idea regarding *hejamat* became much stronger.

He sees himself as a person whose duty it is to promote *hejamat*. I have seen many songs about *hejamat* that were written by him. In every contact with a person, familiar or non-familiar, he describes the advantages of *hejamat* and the fact that this tradition is a necessary part of Islam that should be revived. Ghasem Parvaz has four sons and two daughters. One of his sons is in the United States, the other works as a *Hajam* in the Clinic of Alternative Medicine in Tehran. One of his daughters works in a general practitioner office as a *Hajam*. His wife manages his private *hejamat* office in Tehran.

This participant observation shows again the universal phenomena of death and rebirth in shamans as proposed by Armin Prinz and shows how in a religious society like Iran such quasi-shamanistic cults can work parallel to the ecclesiastical religious cult.

Fig. 3: The Hajam reading a poem for me

Acknowledgment

I wish to thank Prof. Armin Prinz, Head of the Department of Ethnomedicine, who supervised me during my field study, and also Prof. Karl Holubar who gave me permission to work in the Institute for the History of Medicine of the University of Vienna.

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Book Review

Ruth Kutalek
Heinrich, Michael: Ethnopharmazie und Ethnobotanik. Eine Einführung. Wissenschaftliche Verlagsgesellschaft mbH Stuttgart 2001, 159 p., ISBN 3-8047-1775-6,

Ethnobotany, Ethnopharmacology and Ethnopharmacy are scientific topics that are becoming more and more relevant. The interdisciplinary character of these sciences, however, makes it difficult to find an appropriate way to document these topics which is acceptable for social scientists as well as natural scientists. This is what Michael Heinrich skillfully managed in his book. It is comprehensive, clear, informative for social anthropologists, pharmacists, pharmacologists, for people from the medical profession as well as students and interested lay people.
Heinrich starts with an introduction that addresses the main questions regarding the relationship between human beings and plants, the importance of social anthropology, ethnology and ethnobotanic research, stressing the relevance of an interdisciplinary research approach. Chapters two and three deal with the history of ethnobotany and give a very good overview of the field methods used. Here he also argues why he applies the rather unusual term ethnopharmacy instead of ethnopharmacology. Ethnopharmacology means specifically the survey of pharmacological effects of substances used in indigenous medical systems. To stress also other pharmaceutical aspects – galenic, bio-availability, metabolism of active ingredients or the importance of isolated substances – he finds the term ethnopharmacy more appropriate. It has to be stated, however, that Heinrich's definition of the term ethnopharmacology is out of date. Ethnopharmacology more and more stresses its "ethno" side, considering the emic views of people's attitudes towards their materia medica.
Chapter four gives an introduction into medical systems, especially stressing the importance of indigenous classification of diseases for ethnobotanic research. The following sections deal with poisons, hallucinogens and other psychoactive plants, the importance of medicinal plants in western biomedicine, plants as foods, issues of biodiversity and the economic use of medicinal plants. Finally Heinrich gives us an outlook into which research issues will be relevant in the future as regards ethnology and the pharmaceutical/biological sciences. Throughout the book one finds small sections – portraits of important scientists, plants or ethnic groups – which can be read separately and which give additional information to the main topic without interrupting the flow of the text.
This small book is an enrichment to ethnobotany and ethnopharmacy. Unfortunately it is only published in German but an English translation would be very welcome.

Lectures of Our Department

Armin Prinz: 510 038 Nutritional Anthropology (VO, 2hrs.)
Start: Wednesday 10 October 2001, 5-6.30 p.m., Institute for the History of Medicine, auditorium (Josephinum), Währingerstr. 25, 1090 Vienna

Armin Prinz: 510 029 Seminar Ethnomedicine (SE, 2hrs.)
Start: Wednesday 10 October 2001, 3-4 p.m., Institute for the History of Medicine (student's room), Währingerstr. 25, 1090 Vienna

Ruth Kutalek: 510 040 Ethnomedical fieldwork (VO, 2hrs.)
Start: Tuesday 9 October 2001, 1.15-2.45 p.m., Institute for the History of Medicine, auditorium (Josephinum), Währingerstr. 25, 1090 Vienna

Bernhard Hadolt: 611306 Concepts of Medical Anthropology (VO, 2hrs.)
Start: Tuesday 9 October 2001, 3-4 p.m. Institut für Ethnologie, Kultur- und Sozialanthropologie, Übungsraum

Damar Eigner: 720 077 Shamanic Therapies (Vo, 1hr)
Institute for Tibetology and Buddhism
1090 Wien, Spitalgasse 2 Hof 2

Public Lectures

"University meets public" Volkshochschule Wien in cooperation with the University of Vienna

Ruth Kutalek: Traditionelle Therapien in Tansania (Traditional Therapies in Tanzania): VHS Brigittenau, Wednesday 7.11.2001 6:00p.m.-7:30p.m.; VHS Alsergrund, Wednesday 28.11.2001, 7p.m–8:30p.m.

Doris Burtscher: Traditionelle Heilmethoden der Seereer Siin im Senegal (Traditional Therapies of the Seereer Siin in Senegal) VHS Alsergrund, Wednesday 12.12.2001, 7 p.m.; VHS Floridsdorf, Monday 17.12. 2001, 6:30 p.m.–8 p.m.

Forthcoming Congresses

The 12th International Conference on "Humanistische Medizin" – "**Soul in Medicine**" organized by ZIST and Reichert will be held between 31 October to 4 November 2001 at the Congress Hall in Garmisch-Partenkirchen, Bavaria, Germany. As guest speakers are invited: Sfren Giversen (University of Copenhagen, Dept. for Theology), Max Schuepbach (Lava Rock Clinic Network, Oregon, USA), Wolf Büntig (ZIST, Penzberg, Germany), Rupert Sheldrake, (Cambridge), Marianne Carolus (Germany), Dawn Nelson (Compassionate Touch", USA), Stephanie Merritt (GIM, Guided Imagery and Music, USA), Bert Hellinger (Systemic Family Therapy, Germany), Michele Cassou (USA), Sandra Maitri (Ridhwan School, USA), Brant Secunda, Shaman in the tradition of the Huichol-Shamans (Dance of the Deer Foundation, USA), and Tuti Hinekahukura Aranui, Maori healer, "wise woman" and consultant (Aotearoa/New Zealand) and her Hawaiian friends Carmelita Kinau Kapu Saffery ("Dutchie") and Pua Ka' aihue.

Information & Registration: Reichert Organisation; Am Erlbach 7, D-82386 Oberhausen
Fax: 0049-8802-90 73 38
Info@reichertorga.de; www.humanistische-medizin.de

International Congress of Anthropology of Food, XVII Congress of the International Commission for the Anthropology of Food (ICAF)

"Food and Cultural Arbitrary. Rationality and Irrationality in Food Consumption"
Homage to Dr. Igor de Garine
Borja, (Aragon, Spain) 22nd to 24th November 2001
Organisers: Multidisciplinary Team for Research on Human Food (EIMAH) University of Zaragoza, Spain

The congress will focus on the discussion and debate of the so-called "cultural arbitrary" in its relation to human food. What conditions and limits food selection (why do we eat what we eat?) in every society is of prime importance. Food choices affect natural environment as well as the management and planning of resources and they have repercussions on the health of the population. It is necessary to distinguish and specify the factors that influence food selection, its dependence on "rational" biological, ecological, economic determinants, as well as on other factors which are arbitrarily shaped by culture, and the effect of the interrelation between both.

Papers will be submitted in Spanish, French or English.

Scientific Secretary
Dr. Luis Cantarero, Dr. F. Xavier Medina, EIMAH
Facultad de Veterinaria, Universidad de Zaragoza
c/ Miguel Servet, 177, E-50013 ZARAGOZA
E-mail: eimahco@viajeseci.es

Göttingen International Ethnographic Film Festivals
8. – 13. May 2002

Following the great success of the first five Göttingen International Ethnographic Film 00 Festivals, IWF – KNOWLEDGE AND MEDIA announces the sixth festival, due to take place in Göttingen in May, 2002. As before, it will be organized by IWF and take place on the IWF premises. More than 40 new ethnographic films from German-speaking countries and abroad will be presented, thus strenghtening international communication within Visual Anthropology and, at the same time, building a bridge between Cultural Anthropology and Folklore.

The festival is open to all filmmakers from Anthropology, Folklore and neighboring disciplines. The programme will reflect a wide spectrum of films from many regions of the world and representing a great variety of film styles. Göttingen with its central position in the heart of Europe will become once more the focus of attention for filmmakers and other interested people from East and West. The festival also puts emphasis on the support of student films. The Student Competition will also be held in 2002, and the first prize for the best student film will be awarded. Films by filmmakers who were students at the time of the film's date of publication qualify for the competition. All submitted films for the Student Competition and the Main Festival will be reviewed by an International Selection Committee consisting of six outstanding visual anthropologists.

Deadline for film submission and delivery of preview-tapes: January 15, 2002. Forms for Registration and Film Submission may be ordered from and mailed to:
IWF - Knowledge and Media
c/o Göttingen International Ethnographic Film Festival
Nonnenstieg 72
D-37075 Göttingen, Germany
Phone: +49 551 5024 170
Fax: +49 551 5024 403
E-mail: gieff@iwf.de

The next **Intercongress** of the **International Union of Anthropological Sciences** will be held in Tokyo, Japan, September 22-28, 2001. The theme of this conference is: "The Human Body in Anthropological Perspective" For further informations contact the homepage www.the-convention.co.jp/inter2002 or Prof. Keiichi Omoto, International Research Center for Japanese studies, 3-2 Oeyama-cho, Goryo, Nishikyo-ku, Kyoto 610-1192, Japan.

Congress Reports

An **International Symposium on Lycium Species** convened 6-9 August 2001, in Ningxia PR China. The Chair of the Scientific Program, Professor Xiao Peigen, was assisted by Vice Chairs Professors Jan Bruhn (Sweden), Nina Etkin (USA) (all three, former Presidents of the International Society for Ethnopharmacology), H. Wagner (Germany), Tsuneo Namba (Japan), and Cherl-Ho Lee (Korea). Twenty-three researchers discussed the healthful properties of Ningxia wolfberry (Lycium barbarum L.) and related species, highlighting pharmacologic and clinical evidence for immune-stimulating, anti-inflammatory, eyesight-improving, and other "anti-aging" actions. Conference participants were further instructed in new achievements in Lycium research and anti-aging Chinese medicine products through demonstrations at the Lycium plantations and germ-plasm resource nursery (Ningxia Academy of Agriculture & Forestry Sciences [NAAFS] Research Institute) and the Ningxia Government Lycium Products Exhibition. The symposium was sponsored by The People's Government of Ningxia Hui Autonomous Region, and organized by Peng Yong in conjunction with NAAFS, and the Shanghai Industrial Investment Company. Lycium products are an example of province-level development of indigenous resources with potential for both national and international investment and global distribution.

Nina L. Etkin

From the 20-23 September 2001 "**Working Images**" – A joint meeting of the Teaching Anthropology Network and the Visual Anthropology Network of the European Association of Social Anthropologists took place in the Museu Nacional de Etnologia, Lisbon. The first evening showed Paul Fejos' work in a retrospective and it was discussed if his films could be seen as ethnographic or not. The topics of the following days were centered on three main areas: photography in anthropological teaching, research and representation; iconography in anthropological teaching, research and representation; the use of visual images in anthropological museums. Participants came from all over Europe and USA and from various professional backgrounds and institutions. Many showed high proficiency in their work. Those who dealt with the very practical problems of visual anthropology were especially interesting. It was, however, a little disappointing that only five participants, three of whom were from our department, decided to choose the poster as a form of presenting their findings. It was after all a meeting on visual anthropology and visual media should have been emphasized more. The films mostly shown in the evenings after a long day of oral presentations were impressive in their technical quality and critical content. The late evenings ended with fabulous dinners in various Lisbon locations. The organizers Sarah Pink, László Kurti, Clara Carvalho and Ana Isabel Afonso did an excellent job.
For more information see: www.lboro.ac.uk/departments/ss/workingimages/menu.htm Ruth Kutalek

Call for Papers

Artemisia
The Artemisia journal aims to explore international health issues through the human sciences, with special emphasis on traditional medicines. It addresses central problematic of contemporary development through an inter-disciplinary approach involving development professionals and social specialists. The aim is to extract the essence of a development which considers local social realities, representation of health and disease, re-interpretation of development activities, vernacular health practices and pharmacopoeias, etc.
This journal, initiated by the international organisation Nomad RSI (Research and international aid applied to traditional medicines), constitutes a tool for development workers and a place forinterdisciplinary expression for researchers from both the South and the North. The articles are the results of original studies using traditional medicines as a filter to understand the society and its contemporary challenges. They are medium sized and concern the following disciplines: anthropology, social ethnopharmacology, ethnopsychology, ethnobotany, development studies, human ecology and indigenous rights.

Direction and publication
Laurent Pordié, Laboratory of Human Ecology and Anthropology, University of Aix-Marseille / Nomad RSI, France.
Sébastien Gonzalez, Nomad RSI, France.

Honorary Council
-Jean Benoist, Laboratory of Human Ecology and Anthropology, University of Aix-Marseille, France.
-Graham Dutfield, Working Group on Traditional Resource Rights, University of Oxford, England, UK.
-Thimothy Dye, Division of Public Health, University of Rochester, New York, USA.
-Jaques Fleurentin, French Society of Ethnopharmacology.
-Pierre Lieutaghi, Ethnobotany Dpt, Ethnological Museum of Salagon, France.

Deadline for articles submission for the first issue: November 2001.

ARTEMISIA
C/o NOMAD RSI
36, rue Bernard Mulé
31400 Toulouse, France
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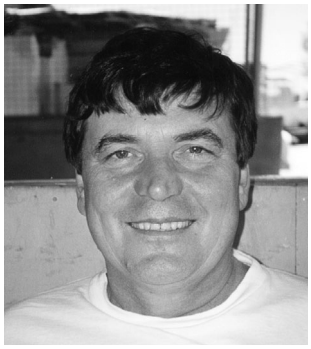

Armin Prinz, M.D., Ph.D. (social anthropology), head of the Department of Ethnomedicine (University of Vienna), since 1972 research among the Azande in Zaire

There is no photo available of Mohammad because he is at home (see page 22).

Mohammad Shekari Yazdi, M.D., Ph.D. (philosophy), dermatologist, collaborator of our department with main interest in Shiite medicine

Alexander Weissenböck, M.A. (social and cultural anthropology) is researcher in our department's project "Documenting the Ethnomedical Collection" which is financed by the Austrian National Bank

Photograph last page

This painting of late Moke (see page 13 f.) shows a vaccination campaign against smallpox in former Zaire. It belongs to our Collection of Ethnomedicine.

Vaccination campaign

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