

Title: Medical Beliefs and Behavior in Culture, Social Structure, Internal and External Group Relationships in North Thailand

Principal Investigator:

David H. Marlowe, Ph.D.

Objective: This study focuses upon the role played by medical beliefs and behavior within the social system and in the internal and external relationships of an upland minority group of Northern Thailand. Its purpose is to analyze and compare those aspects of social behavior organized in terms of concepts of health, illness, curing and "preventive medicine" with those organized in terms of kin and other social relationships, economic production and exchange, religion and ritual, and other aspects of social relationships. It examines these relationships in terms of family, village, and region; contrasting variants within the same cultural group, S'kaw Karen, and analyzes the relationships of specific villages and areas of S'kaw Karen with members of other ethnic groups, primarily North Thai and Meo.

Description: The present work is being carried out in two primary research areas: Tambol Borkeo, Amphur Samerng, Changwad Chiangmai; and Tambol Mae Klang, Amphur Chom Tong, Changwad Chiangmai. The first research center is at the S'kaw Karen village of Norn Klissu Tambol Borkeo, a hamlet of sixteen households and eighteen families. There are two secondary hamlets which arose from Klissu, which are also included in the primary research focus, Klissu Ki and Klissu Ta. The second research site is the lowland S'kaw village of Mae Tia Glo, Mae Klang, Chom Tong. This latter village is comprised of twenty-one households with twenty-six nuclear families. Also included in the primary study is a secondary hamlet, Moh Ti Koh, of thirteen households which took its origin from Mae Tia Glo some forty years ago.

In both of these primary centers the standard techniques of social anthropological field research are employed; participant observation, depth interviewing, photo-recording, tape recording of verbal materials, and extended questionnaire protocols. A family by family base of detailed data covering all pertinent areas of study is being built up. In addition to the primary research areas, a more selected data base on other Karen communities is being built up through questionnaires, surveys, and distributional studies in hill villages of Central, Central Western, and South Central Chiangmai Province.

General Description: The Karen are the largest upland minority group in Northern Thailand. Present unofficial census figures seem to indicate a total population in excess of 125,000, some 45% of all hill people in the North. Of these some 80% are estimated to be S'kaw; i.e., that group of Karen who call themselves Bukunyo or Bukunyo Jraaw. For the most part they live in small settlements of an average size of 14-17 household units in the high valleys and upland ridges of Chiangmai, Mae Hongson and Tak. There are as well a large number of lowland villages at the base of a number of foothill areas. There would appear to number about twenty or so households on the average.

The pattern of wider socio-political integration of the Karen village is shifting and variable; different areas of life and types of social events call forth different wider group relationships. The fundamental unit is the individual hamlet, and it may be taken as given that this comprises the maximally corporately recognized group for 80-95% (dependent upon geographic area) of all normal activities. Each hamlet has its own ritual leader or Geh Sapwaa Damukha, and its own secular leader, Geh Sapwaa; the latter is either the government appointed Payaiban (i.e., village headman) or his deputy. In many cases these roles are filled by the same person. In all affairs involving the government the individual hamlet functions as a part of the government Mu (i.e., village) under the Puyaiban's responsible in turn to the Kamnan (chief commune official) and decisions are taken by consensus of the adult males in all the hamlets of the Mu.

Certain events, such as weddings and funerals, require cooperative participation by a wider group of hamlets, usually all of those hamlets which have split from a single village within the past forty or so years. Normally these hamlets are no more than fifteen minutes walk away from each other. Unlike more recently

migrant hill people, the Karen village is geographically stable and most new villages are founded within or near the valley of traditional habitation. This area of Vwaw represents the widest corporate group and is defined primarily in terms of land usage rights. This is the group that traditionally has the sole right to cultivate upland fields in a given area. For the most part, the people of any of these given areas are a self acknowledged complex of bilateral consanguineal and affinal kin. More pertinent ties are those established both between complexes of hamlets in a given area and other "areas" by "husband exchange;" i.e., Karen villages are ideally preferentially exogamous with a young man marrying and taking up residence in the wife's village. These "exchanges of husbands" appear to follow definite reciprocal patterns.

Economically, most Karen are subsistence farmers with a minority of larger proprietors who are rice exporters, and another minority of landless people who engage in a variety of forms of wage labor; wood-cutting, elephant handling, mining, agricultural labor, etc. Preferentially the agricultural system in Borkeo, Chom Tong, and Mae Chaem is based on wet rice culture with secondary reliance on shifting cultivation of upland rice. In Borkeo and the high upland areas of Mae Chaem there has been a marked shift in recent years to the cultivation of the opium poppy as a cash crop following its introduction by the Meo, compounded in Borkeo by the loss of much paddy land to the tin mines. Stock raising, gathering of forest products, and cultivation of secondary crops; e.g., peanuts, garlic, onions, and soy beans all represent ancillary sources of income.

It is also important to note that the Karen, like all other hill people in the north, do not exist in either social or economic isolation but are tied to their neighbors, both North Thai and other hill people, in an intricate web of social and economic relationship.

Progress: Good progress has been made during the past year. A second research center, Mae Tia Glo at Chom Tong was chosen, a field house built and work begun in July of 1966. The ensuing months have seen the amassing of a great deal of data, both specific to the ethnography of Mae Tia Glo and comparative materials relative to both variance from and similarity to the Borkeo research area. Surveys centering on the use of the traditional herbal pharmacopia, use of government medical facilities, and the relationships of types of healing and curing ceremonies to cult and self-identification differences among S'kaw Karen groups were carried out in Mae Sarieng (May 1966) and the Doi Intanon area of Chom Tong (June 1966). A further extensive survey expected to ultimately reach 700-1000 families in Amphurs Mae Chaem, Sanpatong, and Chom Tong (Changwad Chiangmai) is presently under way. This latter is a general socio-economic and medical resource utilization questionnaire, that will also serve to delineate the gross inner and outer relationships of the Karen natural social areas (Vwaw) of Central, West Central and South Central Chiangmai.

While limitations of space preclude any extensive discussion of substantive materials gathered during the past year, the following brief discussion of the Karen descriptive and classificatory system for illness will give an idea of the direction of the past year's work.

The initial descriptive/classificatory differentiation that Karen make of illness is the dichotomy: whole body illness versus part body or localized symptom illness. This initial description is a linguistically founded mode of classifying and describing. The category of whole body illness involves fever and/or feeling states and, syntactically, represents the only area of conceptualization of illness in which the self is the object acted upon by the "illness entity." Injury and assault are handled equivalently in Karen syntactic structure.

These three cases are:

Fever

Tukabuu naa o
Fever you (obj) has

or

Fever has you

and three generalized feeling states:

| | |
|-------------------|---|
| Feeling not good | Tadaamuv naa o Feel no good you (obj) has |
| or | Feeling not good has you |
| Feeling sick | Tadaagi naa o Sick you (obj) has |
| or | Sick feeling has you |
| Feeling very sick | Daachaa naa o Sick (or hurt) you (obj) has |
| or | A very sick (or hurt) feeling has you |

All other illness is linguistically handled as possessed by the individual afflicted. There are two gross conceptual categories:

1. A known disease entity: these are either classifiable as generalized "visible symptom" ailments, measles, pox diseases, skin eruptions, cough; e.g.,

| | |
|----------------------|---|
| Nuh daa cha po paw o | You (subj) sickness redspots have You have measles |
|----------------------|---|

or a collection of associated symptoms commonly enough occurring to be considered a single disease entity:

| | |
|----------------------------------|---|
| Nuh badaamu o You "cold" have | You have a cold |
| "cold" | light fever, running nose, sore throat, cough, etc. |

2. The most extensive category used by Karen in describing and classifying illness. Name of body parts and associated state seen as possessed by the individual afflicted: e.g.,

| | |
|--|-------------------------|
| Nun huh puu cha o You stomach hurt have | You have a stomach ache |
|--|-------------------------|

Most illness is presented in terms of this final category, that is, as a list of body parts and associated state. Thus, the normal response to the question:

| | |
|-----------------------------------|--------------------------------|
| Daachaa naa a ? Sick you has ? | What sickness <u>has</u> you ? |
|-----------------------------------|--------------------------------|

Will be a body part + state list

| | |
|--|---|
| Yuu huh puu cha o Cosa cha o Huupuuluu o | I have a stomach ache headache diarrhea |
|--|---|

The most common associated states in order of occurrence as symptom presentation are:

1. Chaa = Hurt or ache. This is the most usually presented.
2. Krrey = Hot, hot and upset; as huhpuu krrey, stomach hot and upset.
3. Kuh = Heavy feeling.
4. Ssuu = Irritated and aching; used of eyes only.
5. Klee = Cold, chill.
6. Daagi = Sick feeling, sometimes used as a localized qualifier in addition to its use as a whole body state possessing the individual.

None of these conceptual categories is seen as mutually exclusive. An individual may respond to the question: "How are you sick?" "A fever has me, I have a cold, hot stomach, etc." dependent upon subjective importance of individual symptoms to the individual at the moment of presentation.

All illnesses either as entities or collections of body part states are both classified as either large illnesses or small illnesses, and are also perceived as having normal temporal spans and intensities.

Small illnesses, or daachaa daa do daa chii, are those that are at worst an inconvenience, are non incapacitating, and do not prevent the individual from performing the bulk of his or her daily chores. A large illness or daachaa luu anah guu duu, is one that does incapacitate or prevent an individual from performing his daily chores.

The normal span and intensity of an illness might best be defined as the period of anticipated and acceptable indisposition, pain, or dislocation of normal routine. During this period little thought is given to anything but symptomatic relief. The usual medications that will be used, if medication is resorted to at all are aspirin, APC, and traditional herbals. "Small illnesses" are usually not medicated at all and many people consider the concept, "goes away without using medicine" to be a necessary attribute of small illnesses. If causative agents are thought of at all they are thought of in generic terms, and are those things that are part of the ordinary background of living, heat, cold, sun, wind, food, etc.

As further data is collected, reduced, and analyzed the goal will be to establish the relation between the conceptual classes of illness present above, other conceptual classes, health oriented behavioral patterns, and the other social relationships observed in the Karen populations being studied. The findings in one community of Karen will be compared and contrasted to the forms found in another community.

Summary: The study of medical beliefs and behavior in culture, social structure, internal and external group relationships in North Thailand continues as per the research program. Comparative data collection in all sub-field stations will continue throughout the year in both research centers, Samerng and Chom Tong. It is anticipated that the coming year will see the completion of gross data gathering and an intensification of detailed data gathering and analysis.