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Pocahontas Goes to the Clinic: Popular Culture as Lingua Franca in a Cultural Borderland

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Abstract

Urban hospitals constitute an example of what is arguably the most visible site in anthropology these days—the border zone. Negotiating health care requires trafficking in tricky spaces where patients and their families must pay vigilant attention about when to submit, when to resist, and how to collaborate. Drawing from ethnographic research carried out over the past nine years among African American families who have children with severe illnesses and disabilities, I examine how children's popular culture operates in the fraught borderland that constitutes the urban clinic. Global icons like a Disneyfied Pocahontas can function as a lingua franca, offering a language of publicly available symbols on which families, health professionals, and children can draw to create a shared imaginative space across race and class divides and across the sometimes even more radical divide between sufferer and healer.

Keywords

health care; cultural icons; narrative; child identity; modes of communication

The first time I met Pocahontas in a hospital was in the mid-1990s. Of course, as a U.S. citizen, I had known her since childhood. But I had forgotten all about her until she appeared, quite unexpectedly, in hospitals in Chicago and Los Angeles where I was carrying out research. She looked very different than I remembered. Older, and less, well, historical. She had been dusted off, Disneyfied, transformed into a gorgeous teenage beauty with a head of the most magnificent black hair and a body as enviably proportioned as Barbie. She could sing too. And it was Disney who sent her to the clinic. For not only was she a larger-than-life figure in a popular animated movie, she was packaged into craft sets, costumes, dolls, and an array of other cultural artifacts that began to find their way into all sorts of children's places—including children's hospitals. She traveled internationally as well. I saw her once, resplendently arrayed, hair flowing, on a large poster board in a duty free shop at the Copenhagen airport. Internet chat rooms carried on worldwide conversations about her adventures. Pocahontas had gone global.

This apparently frivolous example of the circulation of global goods has special and, indeed, profound significance in the context of health care, as I have gradually come to realize. Drawing from ethnographic research carried out over the past nine years among African American families who have children with severe illnesses and disabilities, I examine how children's popular culture, exported by such mass media empires as Disney, operates in the fraught borderland that constitutes the urban clinic. Children's films and television programs

provide characters and plights that are creatively localized in health care encounters. A child's beloved character can offer a kind of narrative shadow, a cultural resource that children, families, and health care professionals readily turn to in the ongoing task of creating socially shared meaning, especially the sort of meaning that has to do with trying to positively shape a child's future.

Stories, it has long been noted, tend to provoke the imagination. They spur us to consider life in the subjunctive mode (Bruner 1986, 2002), in terms of a “what if” universe of possibilities. Thus, it is not surprising that anthropologists have looked at the way stories created by global media inspire new imaginative constructions of lives and worlds. The study of media has been intimately connected to the reinvention of culture as a contested space, a point of particular relevance to this article. Media is often treated as a force for constructing a distinctive identity—for creating boundaries and marking distinctions—but here I explore it as a vehicle for creating commonalities. Its role as mediator between the worlds of family and clinic takes on special importance in clinical encounters marked by differences in race and social class. Children's popular culture offers resources for building bridges among groups who perceive themselves as Other but who are compelled to collaborate because of the need to tend to a sick or disabled child. A Disneyfied Pocahontas is only one of the mass-marketed figures that plays an important role in the clinic, especially in creating “common ground” between the world of the hospital and home, and among the various key actors who care for severely ill or disabled children. Global icons like these can function as a lingua franca, offering a language of publicly available symbols on which families, health professionals, and children can draw to signal a common heritage or to create shared imaginative space across racial, class, and sufferer–healer divides. Why is a trade language so necessary in the U.S. urban hospital?

When Culture is a Borderland: The Urban Clinic

Urban hospitals constitute an example of what is arguably the most visible site in anthropology these days—the border zone, which James Clifford describes as a place of “hybrid cosmopolitan experiences” (1997:25). Border zones have emerged as part of the refiguration of culture, a shift from the discipline's traditional task of elucidating “the crystalline patterns of a whole culture” to a focus on “the blurred zones in between” (Rosaldo 1989:209). Anthropologists have been moving from the heartlands to the borders for quite some time. This has meant a shift away from studying isolated communities in favor of geographic areas—such as urban centers or national border zones, which are characterized by ethnic pluralism and a fast changing cultural scene. It has also meant paying special attention to sites of heightened commerce among actors who are culturally diverse. A focus on border zones is part of a fertile rethinking of traditional concepts of culture by anthropologists and culture theorists.

In a borderland, culture emerges more vividly as a space of encounter than of enclosure. For many, culture has come to designate a noisy, pluralistic, contested, ever-changing public sphere, rather than a substance, common property, or a shared commitment to a way of life. This perspective emphasizes connections—including media-created connections—that are often political and often unexpected among these diverse communities and commodities.¹ Viewed in this way, culture is not to be found in a group's shared set of beliefs and values so much as in its practices of drawing contrasts and boundaries with other groups as well as

¹A number of scholars have explored how mass media produces connections and even diasporic communities in ways that further complicate any simple use of the term *culture* (Abu-Lughod 1991; Appadurai 1991; Diouf 2000; Erlmann 1996; Mbembe 1992; Metcalf 2001; Pollock et al. 2000; Price 1999; Schein 2002).

challenging those contrasts. This sort of cultural world is characterized by politically charged, difference-making exchanges among actors.

The clinical world has often been recognized as contested terrain. The urban hospital is a place in which misreadings and conflicts routinely arise. The United States is growing rapidly more ethnically diverse, and this means that health care increasingly involves providing treatment for diverse populations. Urban health care in the United States is characterized by a dizzying array of languages, nationalities, racial identifications, social classes, and religions.² It has been well documented that ethnic diversity is accompanied by unequal access to health care. Racism also plays a key role in adverse health outcomes. African Americans continue to be one of the least well-served minority groups, a recognition that has provoked examination of the connections between race and health.³

A great deal of the work in medical anthropology has explored transactions within biomedical encounters marked by cultural confusions and misunderstandings—border talk, in fact. But the figure of clinic as border zone takes on a decidedly less familiar cast when situated within the recent debates about culture, place, and space that have arisen among scholars far removed from anything clinical—those who have been delivering, or responding to, challenges concerning the location of culture in the face of a globalizing and decolonizing world. This work offers an intriguing vantage point for examining the border activities of health care practices. In this discursive context, the familiar figure of the misunderstood patient emerges as startlingly emblematic, an exemplary citizen of that new nation, the land of the culturally in-between. If the practice of culture is, in part, the practice of Othering, of identifying cultural (and racial) difference in a thousand subtle and unconscious ways, this is of special importance in clinical encounters. Failures of communication are magnified to intense proportions in situations characterized by both perceptions of difference and high stakes. Cultural identities constructed by race, class, gender, and other potentially stigmatizing markers take on profound meaning here. What might, in another context, be a small slight or a confusing conversation, can, under these heightened circumstances, take on enormous importance. To feel neglected by one's doctor when one's child is seriously ill is not the same as being ignored by the grocery clerk.

The primary research that informs this article is a longitudinal ethnography that began in Los Angeles in January 1997 and is still ongoing. It has been carried out by an interdisciplinary team of anthropologists and occupational therapists. We initially recruited 30 African American families from the Los Angeles area whose children (ages from birth to eight) were being treated in several clinical sites. Most, although not all families, were low income. Eighteen of those initially recruited have continued to participate. Others joined subsequently as some families left the study for various reasons (e.g., moving out of state). All families now participating have been part of the project for at least three years.

²See Good et al. 2002, Cooper-Patrick et al. 1999, and Doescher et al. 2000.

³In a careful review of research findings on health disparities, an Institute of Medicine Committee reported that

minorities are less likely than whites to receive needed services, including clinically necessary procedures. These disparities exist in a number of disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness, and are found across a range of procedures, including routine treatments for common health problems. [Institute of Medicine 2002:2; see also Good et al. 2002]

Although health disparities for all minorities as compared to whites have been consistently documented, African Americans are routinely subjected to the greatest racial stereotyping and to the least access to health services (Bailey 1991; James 1994; Whitehead 1997). Some research indicates this is regardless of social class, education, economic status, or type of health care coverage (Dressler 1993; Good et al. 2002). Other research challenges this in claiming that social class plays a larger role than race, per se, in quality of health care (e.g., Lareau 2002). In any case, it is clear that when race and class are confounded, as they are for most of the families we have been following, receiving good health care services is an ongoing challenge. For further discussion of the connection between race and health, see also Barbee 1993; Jackson 1993; Porter 1994; and Wiloo 2001.

This continuity of families has allowed us to come to know the ebbs and flows of chronic illness and to witness what that means in the never-ending process of negotiating health care with shifting casts of health professionals and changing bureaucratic processes. The research has involved accompanying families to clinical visits, observing and sometimes videotaping those encounters, and separately interviewing participants about what they perceived happened in the encounters. We have also observed and videotaped children and families at home and in the community, especially at key family events. This kind of longitudinal design has revealed a great deal about clinical encounters as events in family lives and about multiple perspectives between families and clinicians as these develop and change over time.

In this article, I provide examples and quotations from clinicians and family members that exemplify some themes that have arisen repeatedly in our data and are important to the arguments I make here. The data I cite come not only from my own interviews and observations but also from research conducted by other members of the research team.⁴

Not surprisingly, a key issue for families concerns whether or not they can trust their clinicians. The most minute nuances and gestures of health professionals (esp. doctors) are routinely scrutinized, becoming a subject of storytelling and puzzling. What are they trying to tell me? parents wonder. What are they hiding? Do they treat me this way because I'm black? A man without a job? A single mother? Do they think I'm a "ghetto mom"? Do they think I'm abusing my child? Are they experimenting on my child? Are they ignoring me because I'm on Medicaid? Do they think I'm not strong enough, bright enough, educated enough, to hear the truth? These are the sorts of questions asked by families in our research, and they are asked again and again. If cultures are spaces in which cultural differences are constructed and Othering is an everyday occurrence, this is profoundly consequential when a child's health or life on the line.

The Hazards of Border Crossing

If health encounters operate in a "border zone," all the key actors—especially minority patients and families—are attempting to cross borders. When children have chronic medical conditions, successful treatment demands cooperation and alliance building among children, family members, and professionals.⁵ This can be a daunting task for all involved, especially when clients have had a difficult time receiving decent health care, as is the case with many of the families in this study. When stigmatizing class and racial categorizations arise, or are suspected of arising, tensions intensify. Mistrust on all sides tends to run high. Othering tactics practiced by clinicians are often subtle and largely unconscious, becoming most visible when patients, including parenting kin, are perceived as noncompliant. Explicit racial designations are rarely used, but there is a common taxonomy of "difficult clients" that is often attached to low-income minorities, a language so polite that its stigmatizing influences are largely undetected by clinicians. In our research with children, negative labels are often affixed to the parents rather than the children themselves. In addition to obvious negative markers—such as the "abusive, noncompliant, or neglectful parent"—there is a language of compassion that can also serve to create difference: the "overwhelmed parent," the "too many things going on at home parent," the "doesn't really understand the clinical picture" parent, or the "still in denial" parent.

⁴For the sake of simplicity and to help protect confidentiality of informants, throughout the article, when quoting participants, I refer to the research team collectively, as in "we interviewed" or "we observed," rather than identifying particular researchers.

⁵General concern to improve the capacity of clinicians to communicate with minority clients has spurred a vast, cross-disciplinary literature on "cultural competence" (Brach and Fraser 2000; Guarnaccia and Rodriguez 1996; Lopez 1997; Pierce and Pierce 1996) and on "culturally compatible interventions" (Takeuchi et al. 1995).

One of the most insidious features of these categories is that when people have been placed in one of them, their capabilities and strengths are hidden from view. This problem is exacerbated by the fact that health care encounters are based on expert models of service delivery: Clients have problems, professionals have problem-solving expertise. This too, can make it difficult for professionals to see the need to identify their clients' strong points or to learn from them. In addition to the problematic categories that abound in informal health care discourse, professionals also learn narrative strategies that can effectively disguise the abilities of clients. They operate with a common set of narrative scripts or work to construct stories that "make sense" of problematic or difficult clients in a way that leaves little room for the client to emerge as an agent, to influence the framing of the problem or the path of treatment (Mattingly 1998b). Although these problematic features of health care are by no means peculiar to minority populations, they are certainly intensified for minorities in which racial designations are likely to influence the clinical encounter.

One place this has emerged with startling clarity in our study is with children suffering from sickle-cell disease. The sickle-cell clinic has been the place where race is most openly discussed by clinical staff as well as parents. One mother in our study remarked that children with this disease are "not being treated with dignity and respect" in many hospitals, a lack of respect that includes parents as well. Because of some humiliating experiences at the hospital in which her child had been a patient for years, she transferred her daughter to another hospital, even though they lacked the same level of expertise in treating sickle-cell disease. She put it this way: "I'm not a radical. I'm not a feminist.... I just think you should be treated a certain way, and I should be treated like the person next to me who maybe is a different skin color."

Several clinicians in our study concurred. One physician who has treated sickle-cell patients for 25 years (and who happens to be white) angrily noted the dismissive way clinical staff tend to view sickle cell, a dismissiveness that also extended to the clinicians who treat such children:

I'll tell you I don't even listen to them, the attendings. They say, "Ah well, we have a chemotherapy patient coming in so we need to send your sickle patient off the floor because this patient's more important." You know? And I won't tell you what I'd like to say to them.... There's very much the attitude that well, this is something that anybody can take care of and it's just like pneumonia. And they don't really believe that there's anything in particular, that special expertise, that's going to help you take care of these kids. And you find out real quick that that's not true.

A vivid illustration of problematic, race-based categorizing is the "med-seeking" label regularly attached to those with sickle-cell disease who go into a pain crisis. Adolescent African American boys, in particular, are often refused crucial pain medication or are seen as crazy, violent, or drug seeking when in a pain crisis. The physician quoted above told the following story in an interview:

Try being a 17-year-old black male with severe pain going into an emergency room and asking for narcotics and see how far you get.... Some of the best advice that I ever heard was from an adult with sickle cell, this is from family day that we had a few years ago. And this adult said, "What you need to do is when you're totally fine, you're not in the middle of a crisis, go to the emergency room and ask to meet the head of the emergency room and sit down for five minutes with him and say, "Hi, my name is blank, remember me? I was an extremist the other night and I'm' just on my way to my law firm today, but you know, but on the way to the business I own or the job I have doing X, Y, Z, I wanted to stop in and let you know that I

don't always go around in my undershirt and underwear screaming, asking for narcotics.”

An African American social worker we also interviewed in this same clinic echoed this: “As soon as the house staff hears there's a sickle-cell patient, something goes up that says, ‘I've got a kid here that's drug-seeking, you know, manipulating,’ without actually doing any assessment of the child.”

The difficulty of not being heard or of being subjected to racially based Othering, although especially articulated with sickle-cell disease, pervades clinical encounters. How do families, children, and clinicians attempt to cross a clinical border zone heightened by racial wariness and mistrust? They cultivate border-crossing skills: They learn to “read the minds” of professional Others, and in light of those readings, to devise strategies to present themselves as worthy of care. Border crossing can be very tricky business because African American clients routinely must be noncompliant to get the care they or their children need. Learning to read the culture of a clinic and of an individual health professional means learning how to execute the right kind of noncompliance that will lead to getting care rather than being turned away or, worse, reported to the social worker as a “problem parent.” One mother explained how she has learned to “shuffle through and play this politicking thing”—that is, to appear compliant even in situations in which she knows more about her child's disease than the professional and may privately disregard what the clinician tells her to do. In situations in which she felt she must fight directly, even when she was proved medically correct, she was then faced with yet more “shuffling” and “playing” the “politicking thing” to reestablish good relationships with estranged clinicians. In other words, she had to apologize and act grateful even when she was right to challenge professionals:

A lot of times you, as parents, you kind of specialize in a disease. You know a lot more than the doctor knows and it's scary when you have doctors that say, “Oh, I'm Dr. So and So” and ... then they say something off the wall and you know that they are completely wrong. And how do you deal with a doctor and his ego? And so that's part of the game that I've mentioned before. You have to know how to shuffle through and play this politicking thing when you shouldn't have to do that.

Children's Popular Culture as Lingua Franca

It is within this charged and wary context that the power of children's popular culture needs to be understood. If failed encounters produce and reinforce narratives of the stigmatized Other, successful ones counter these powerful narratives by producing ones in which clinicians and patients come to share, if sometimes fleetingly, a narrative of mutuality and belonging.⁶ So, for instance, when an oncologist stops an examination to ask a parent about his or her Thanksgiving and to recount a story about problematic in-laws at the dinner, the oncologist speaks, in an important way, to a shared world of values and practices. The ability of professionals to recognize, acknowledge, and build on commonalities that cross lines of race, class, and culture is as important as recognizing the existence of race-based stereotyping or cultural difference.

Common worlds are routinely created in clinic interactions, drawing on cultural resources that are familiar to all the parties. For clinicians who have sustained relationships with clients, the ability of the actors to call on the small things—a joke remembered, a movie just seen, a disastrous Thanksgiving dinner—can be extremely powerful in forging bonds across formidable social divides. The importance of doing this has been noted repeatedly in the

⁶This point was brought home with force in the way the African American families in our study talked about the meaning of September 11th. They underscored not only the concern to be designated as different from Euro-Americans but also the need to be recognized as sharing a common national culture and heritage (Mattingly et al. 2002).

African American community with whom we have been involved. When things go very well in a clinical interaction, as they sometimes do, an important ingredient is that patients, clinicians, and even family caregivers are able to “read” one another well enough to create a shared narrative. That is, they are able to participate as actors in an unfolding story they help construct, one for which they have real commitment and one that embodies or suggests healing possibilities. This is what I have elsewhere called a “healing drama” (Mattingly 1998a, 2000; Mattingly and Lawlor 2001). Healing dramas need not depend on the possibility of curing; in fact, they can embrace death. But they do depend on moments in which shared experiences are created between professionals and clients. Such moments can draw members together even when they come from diverse social positions.

As it turns out, popular culture as offered up by mass media plays a critical role in facilitating the construction of these shared narratives. Global popular culture is often drawn on by families and health professionals to develop a shared story of hope. By *shared*, of course, I do not mean that health professionals and clients come to see or experience things in the same way, but that, at minimum, there is sufficient consensus to agree about treatment options and other practical matters and there is a sense that everyone is working in the best interest of the child. At times, though, there is a kind of collective imagining that goes far beyond this minimal level. Stories from children's popular culture are woven into clinic life and into interactions with home health professionals. They become part of stories acted out or referred to, especially during rehabilitation therapies that try to incorporate treatment into some form of child play. Rehabilitation therapists and aides mention that to treat children, they find that they need to watch the same movies that children are seeing simply to be able to understand them in therapy. Children repeat phrases or initiate actions in therapy that imitate their favorite film stories.

It is no surprise that characters from Disney films turn up with such regularity in pediatric hospitals and find their way into all kinds of clinical sessions. Disney has been the primary exporter of children's popular culture for decades, a matter that has long provoked critiques from, for example, critical social theorists of the well-known Frankfurt School.⁷ The power of mass media to shape cultural identities has also been a topic of central concern within contemporary culture theory. Stuart Hall, for example, has argued that mass media is a primary vehicle for ideological production, a means through which groups construct images of their lives (Hall 1997). Mass media might be colonizing but ethnographic studies of the actual practices of cultural production and reception help to complicate the picture of media as ideology machine. Such studies reveal the way that the global is made “local” in specific contexts and show that the meaning of a media text is not given by the text itself but by the processes through which it is taken up and consumed by particular interpretive communities (Abu-Lughod 1991; Metcalf 2001; Rapp and Ginsburg 2001). Reception theories in media studies have been at pains to argue that meaning is a complex and local practice of negotiation between the world of the text and the world of the audience. It is a historically particular and local invention (see Spitulnik 1993 for a review of this literature). In other words, the audience does not merely consume, it “poaches,” as Michel de Certeau (1984) puts it, helping to construct meaning through its practices of consumption.

Consuming Popular Culture: Children and Families

Children's popular culture (esp. Disney) is everywhere in the lives of this African American community. Disney and other popular culture products have a fundamental role in the ongoing (playful) practice of these children as they imagine themselves in various scenes, playing various parts. In these playful constructions of possible selves, characters gleaned

⁷See Henry Giroux's (1999) critique of the Disney empire for a fascinating, and more recent, exposition along these lines.

from Disney (as well as other media) stories provide easily adapted cultural material. Children often try out characters borrowed from scenes in movies or television shows, inviting adults to play their appropriate part in the scenarios they set in motion. The cultural space of Disneyland itself profoundly feeds the imagination of children, shaping a sense of life possibilities even if they are only possibilities that can be played with. For example, one critically ill four-year-old declared, in a fit of wishful thinking, “My daddy’s gonna take me to Disneyland with—with Michael Jackson.”⁸

When young children identify with certain characters in movies and television programs, it is not simply that they like those characters. Rather, they become those characters, at least for moments at a time, and they do so with particular delight when they can find others who will cooperate. Identifications with a particular character are social achievements, for it takes not only the child but the support of those around her for this identity to become “real.” It requires cooperative efforts if these characters are to be incorporated in the scenes of everyday life. Identity play may be initiated or actively discouraged by parents or other adults. When a three-year-old boy declared that he was one of the “Power Puff Girls,” his mother laughingly told us how she dissuaded him from this identification; he received no social support for seeing himself as a girl. This identity work is far from passive; it is actively carried out through a variety of efforts, often orchestrated by parents, in which the ongoing connection of their child with a popular character is insured. Parents tell other important adults—including clinicians—about their child’s favorite movie characters, thus widening the net of those who participate in the co-construction of a child as fantasy figure. They take their children to Disneyland or even far away Orlando’s Walt Disney World to meet “their” special character. They dress children up as these characters for special occasions like birthdays and Halloween. They buy the dolls, coloring books, underwear, lunch boxes, tee shirts, stickers, pillow cases, curtains, and other merchandise that import the character into everyday life. They organize elaborate children’s birthday parties to which dozens of people (including many adults) are invited and at which they recreate scenes from the movie in which their child’s favorite character stars.

It is striking how consistently a child (or parent) chooses a character similar to the child in gender, racial or ethnic identity, or even disability. Even more intriguing, the kinds of adventures these characters face have their parallels in key events in a child’s life. The happy endings that characterize children’s movies and television programs offer hopeful visions of a child’s future in “real life.” Fascinatingly, this match may result from a striking mismatch, where a superhero possesses exactly the qualities that a child conspicuously lacks but longs for. Movie plots and life plots have a curious symmetry, although most often a symmetry by which a character’s extraordinary or magical abilities provide a wishful identification for a child.

Consuming Children’s Popular Culture: The Clinical Community

Pediatric clinicians routinely draw on popular culture to connect with children. This is most apparent and most elaborate in rehabilitation therapies in which clinicians struggle to get children to cooperate with what can be painful or difficult exercises. Especially in acute hospital settings, there is a certain desperation in calling on this trade language. Often there is little time to get to know children who must be asked to participate in activities that are

⁸As Giroux states, Disney is hardly a monolithic empire. Rather, he explains,

The Disney culture offers potentially subversive moments and pleasures in a rage of contradictory and complex experiences. In fact, any approach to studying Disney must address the issue of why so many kids and adults love Disney and experience its theme parks, plays, and travel opportunities as a counterlogic that allows them to venture beyond the present while laying claim to unrealized dreams and hopes. [1999:5]

likely to frighten or pain them. Over the years, we have interviewed a number of physical and occupational therapists about their use of Disney and other mass media narratives in clinical work. I include some of the comments they have made in our interviews about how and why children's popular culture figures so pervasively in health care encounters. One occupational therapist mentioned that she always looks at children's shoes to see what character or movie they like. Another therapist said,

It's not like you have a couple of sessions to develop rapport. You're seeing them just that one time and the parents say, "There's this issue and you absolutely have to get this assessment done right now." And the doctor wants to know what you think right then. And you have to develop a rapport very quickly. And that's when you just grab whatever you can that you can just kind of key into them with.

Certain favorite characters are woven into therapy sessions. Many come from Disney films because, as an occupational therapist noted dryly, "They have a pretty big corner on the market." When there is time to listen, a physical therapist pointed out, it is possible to "let them [the children] lead you," which is the very best way to work. A physical and occupational therapist at a pediatric burn unit reflected on the importance of these characters for the children they treated. The therapist noted, mimicking the children, "Different kids, especially at different ages, tend to attach to different things. Like the girls, like we had so many little girl patients that were really into, like, Snow White."

This attachment is used by clinicians as a "motivator" during therapy sessions. A physical therapist offered this example:

I think we use it as a motivator if they indicate to us that that's something they really like to do. Like my one little girl, Anita, who loves, loves Snow White. I mean it was something. So we would call her Snow White and we would say ... let's have you walk like a Princess Snow White and we'll go over and see if we can drop little things for the little seven dwarfs.

Children's popular culture can provide a "key" into the world of a child's imagination, a world in which the clinician can become an ally rather than an enemy, and one in which a child can do things impossible in ordinary life. To illustrate, I offer the following example. One occupational therapist told a story about how she came to incorporate "Spiderman" into her sessions with a child suffering severe sensory motor problems. This eight-year-old boy was so afraid of heights he slept with his mattress on the floor and refused to play on swings, slides, or monkey bars on the playground. As a result, he spent many lonely hours at school recess and home while his friends and schoolmates played together. During their first clinic session, she found him extremely shy, remembering that "when Manny first entered the clinic, he had his face buried into his mother's side and he would not turn around or make eye contact with me." After several false starts that yielded only silence, the therapist noticed he was wearing a "Spiderman" shirt and shoes. She decided "it was worth a try" to see if Spiderman could draw him out. When she produced a Spiderman coloring book, "a smile began to creep over his face." Coloring the Spiderman book together began their many Spiderman adventures. As Manny colored, he told her of Spiderman's great feats and enemies, and out of this, as she put it, "a pact had been formed for future therapy sessions" for in all subsequent sessions "Spiderman played a prominent role." Manny donned a special Spiderman vest for therapy time. There was one session the therapist described in some detail because she saw it as a turning point in her work with the boy. For this session, she used a rope hammock swing (a typical piece of therapy equipment for children with sensory motor difficulties), which she announced was a spider's web. (The Spiderman's web, in fact.) After much coaxing, Manny eventually climbed into the web with her, although he was so frightened that his teeth chattered. To distract him, she sang the Spiderman Song, which she also recited for me. This song includes such telling lines as

Can he swing from a thread?

Take a look overhead.

Hey there, there goes the Spiderman!

Manny gradually calmed as he heard the song, which allowed the therapist to begin a game of throwing beanbags at various Spiderman “enemies” (beanie babies she had set up in different spots around the therapy room). She took on the voices of these hapless enemies as Manny bashed them with beanbags. He became so enthusiastic that, in an unprecedented moment, he insisted they swing higher and higher so that even while he was in a “tornado” he could “fight against evil.” This therapist was convinced that Manny's capacity to become Spiderman in these therapy episodes was critical to her success with him, as evidenced by his willingness to take on such terrifying challenges as swinging high above ground.

Notably popular icons are extremely versatile cultural resources. The same character can take on different meanings for different children. Whereas for Manny, it is Spiderman's brave capacities to, for example, “swing from a thread” that are salient, for another child facing a different sort of disabling condition, other features become central. For example, Spiderman also became a favorite cultural icon for a boy in our study forced to wear medical masks to treat a severe burn injury to his face. In this case, Spiderman's identity as a “masked hero” is emphasized; in Manny's case, it is his skill at gravity defying leaps through space.

Conclusion

Popular culture provides a common language for adults and children, a set of public symbols that they can draw on to try to connect with one another. Even comparative strangers, like health professionals, can readily draw on them to connect to a child they do not know and who is, likely as not, afraid of them.

Globally circulated and mass-produced texts are made meaningful in local ways and offer powerful cultural resources that serve local ends. Popular culture offers characters and plots that are remade, “indigenized” as Arjun Appadurai (1991, 1996) says, to fit specific needs and circumstances. As the Spiderman examples illustrate, the meaning of a popular media text does not reside in the text-in-itself and can never be reduced to mere “consumption”; it always involves situated constructions that do practical work for particular actors.

Popular-culture stories and heroes provide potent vehicles for overcoming the dreary, frightening, or embattled relations between clinicians and patients and do so in a way that supports hope. When clinicians draw on these loved characters in their interactions with children, they may be connecting with children and parenting kin in a far more powerful way than they sometimes realize. When clinicians speak to families only in the medicalized language of statistical probabilities, especially if prognoses are poor, mistrust is easily heightened. It is not that clients want to be lied to or have medical information withheld. But they are also concerned that clinicians support a subjunctive reading of their child's chances and that they make every effort, even for, as parents sometimes say, “a little black kid” (Mattingly 2004). How can families come to trust that professionals have not “given up” on their children, despite the fact that they have severe disabilities and are African American? In the racial climate of the United States, this is not a question that can be asked and answered directly. Clues must be indirect. It is here that, in its own oblique and playful way, the lingua franca of children's popular culture—when exemplified by, for example, a joking exchange between a nurse and mother about how quickly Spiderman recovered from surgery (the very same surgery a child has just undergone)—suggests possibilities that go far beyond the ostensible topic. In a wary place like the urban clinic, when people are struggling to

connect across all kinds of barriers, a Pocahontas or a Spiderman, one might say, travels well.

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