



From application to implication in medical anthropology: political, historical and narrative interpretations of the world of sickness and health

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Abstract

This article reviews some of the current writing on medical anthropology, and is guided by political orientation/implication in the choice of its study targets, its analysis and its construction of solutions for the problems investigated. Starting from the narratives of anthropologists, it goes on to show the historical and socio-political bases characteristic of the subject in their countries of origin or migration. Within a general overview of the three principal contemporary trends – critical medical anthropology, the anthropology of suffering and the anthropology of biopower – the focus is on theoretical and thematic choices to meet the demand for “politicization” of the anthropological debate in the field of health, on the basis of which an “implied” medical anthropology is advocated.

Keywords: medical anthropology; review of the literature; critical medical anthropology; social suffering; biopower.

In this article, basing ourselves on some of the narratives by anthropologists of the origins of medical anthropology (MA), in their countries of origin or migration, we will attempt to show some of the historical and sociopolitical bases that have defined the features of these national anthropologies. After this, we shall present a picture of contemporary trends in MA, characterized by their theoretical and thematic choices and structured so as to take account of a demand for “politicization” of the anthropological debate in the field of health. For this purpose, we look at some of the North American and European literature in the field of MA, giving prominence to the debate on the political orientation/implication in this specific field of anthropology in the choice of its study targets, its analysis and its construction of solutions for the problems encountered in the various social realities studied, both in the origins of this field of anthropology in various countries, and in the current context of globalization.

We shall start with “narratives of origin,” constructed contemporaneously, with reference to various national medical anthropologies, which are organized to show the local social and political factors responsible for the birth, in each country, of an anthropology concerned with the phenomenon of illness. Some authors, for example, show that in its origins the political implications of MA seem especially linked to a suggested confrontation between traditional hegemonic medical models and the need to provide solutions for the health problems of Amerindian and peasant populations (Castro, 2003; Campos-Navarro, 2010). Also present in these analyses are critical views attributable to expressions of sickness in magic-religious worlds, identified as the historical product of the subordinate relationship experienced by the lower classes, and these are especially eloquent in studies which concentrate on states of consciousness, psychic normality and manifestations of “madness” in various cultures, but also on gender relations and ritualized bodily expressions of female suffering (Pandolfi, 1993). It is worth noting that, in the branch of MA which brings together the topics of ethno-psychiatry or the anthropology of the emotions, the accumulation of ethnographies in societies in which madness has attained different parameters from those which identify its expression as merely pathological, besides being interpreted on the basis of magic-religious cosmologies associated with various popular therapies, it has been fundamental to question dualist western models of health and mental illness, based on naturalist truth regimes. Works of this kind were important for the epistemological foundation, which, in various countries, supported ideological references to anti-asylum struggles and theoretical references to basic community services (Cardamone, Zorretto, 2000). These are themes whose complexity prevents us from dealing with them within the scope of this article, and we refer to them only to indicate the socio-political soil from which they spring and which even today are responsible for a vast number of studies dealing with the place of madness in contemporary society.

From this original fertile soil, MA has evolved as a field of study which expands in proportion to the degree by which its spheres of analysis and operation become more complex, in contexts which combine, in varying degrees, technological innovation, social inequalities, population migration, important social changes, conflict situations and globalization. Its political analysis has progressively come to refer to health as a social phenomenon, which occupies a strategic position in the exploitation of what is at stake on the national and international political scene. The focus is on the social determinants for illnesses (Farmer, 1992), on the new constructs and experiences of illness and of resistance to this phenomenon

(Good et al., 2008), and on the ways in which human rights and health-sickness-care processes can be conceived (Farmer, 2008).

In the construction and transformation of MA's identity, in the sense of recognizing and debating its political implications, there are four aspects that seem important. Firstly, there is the question of the position of anthropology in the field of health at the time of its origin: was it to be merely an appendage of modern biomedicine (and therein lies a criticism of the term medical anthropology), in relation to which it would be simply an "applied technique" (Castro, Farmer, 2005), or, on the contrary, would it maintain its own disciplinary autonomy and epistemology. This autonomy would manifest itself as a result of certain arguments and propositions advocating the hegemony of biomedicine, and was evident both in the affirmation of a pluralist position, showing the legitimacy and complexity of other medical systems (Leslie, 1976), and in the adoption of a deconstructivist strategy, showing the social nature of the construction of illnesses and remedial systems, including biomedicine (Lock, Gordon, 1988), and also by the conception of illness as a key subject, the study of which is capable of revealing the social order which is seen as a metaphor for the biological order (Augé, 1984).

This is closely followed by the charge that anthropology takes a "colonialist" attitude towards non-western peoples studied today (Bhabha, 1997). As a counterweight, a body of theory has arisen of a kind which is specific to ethnographical practice, called "anthropology at home" (Jackson, 1987), in which field work is carried out in the territories to which the researchers belong, whether they are developing countries or first world countries which have developed the so-called "peripheral anthropology" (Oliveira, 1988), or whether they are countries with no colonial tradition.

At another level, this geographical concern of the researcher with his own society answers a social demand in countries that have experienced multiculturalism as a result of immigration, and have thereby become more open to the adoption of social objectives previously considered excessively familiar. It gives rise to the deconstruction of biomedical practices, generally considered "culturally neutral," or endowed with a neutrality and legitimacy guaranteed by their scientific method. This process gains momentum with studies of areas which show cutting-edge knowledge and technology, the "ethnography in the laboratory" initiated by Bruno Latour (1986), and with a study of the impact of their use on daily life (Kaufert, 2000). Curiously, at a time when the gaze of the anthropologist reverts to first world societies, the challenges of globalization are rekindling the interest of the researcher in international relations, encouraged by commercial relationships for cooperation or technological exchange.

A third point is the strong criticism of culturalist anthropological interpretations, which emphasize health practices and techniques, while turning a blind eye towards the social and political dimensions at the root of problems of illness, as well as of the absence of solutions (Singer, 1986; Farmer, 1992). Out of this debate arises the trend known as critical medical anthropology in North America, and the anthropology of health in Latin America and Europe, within which Fassin (2000) adds the sub-trend "anthropology of life politics."

Finally, this movement of self-reflection has produced an epistemological and methodological refinement. Two theoretical standpoints have arisen in MA: constructivist approaches, on a hermeneutic and phenomenological basis; and those termed by Fassin (2005)

as realist, which adopt post-structuralist theories, based on authors such as Pierre Bourdieu and Michel Foucault, or on a re-reading of Karl Marx. The first movement is related to the interpretative turning point and to the anthropology of experience – narratives occupy a fundamental place in their concerns. The second posits a social and political reading of the relationships which link individuals, groups and health. Although, during the most heated period of the debate, the two trends appeared to be opposed, a wider understanding of the subject now tends to allow that both views have a relevant contribution to make in a synthesizing or complementary view of the whole.

During the course of these great debates in the field of MA, a tendency can be observed towards scientific practice directed at themes of great social importance at the global level, based on a vigorous socio-political discourse justified on the basis of a greater involvement in the transformation of social realities, which we call implied anthropology, in order to distinguish it from the semantic and praxeological terms under which applied anthropology is defined. It will be noted that certain current problems are far removed from the study of objects strictly assigned to the field of human illness and need to be understood in a non-health context. In the words of Fassin (2005, p.383), “they raise afresh the queries posed in a more general manner by anthropologists who deal with political and moral questions.”¹ This change in emphasis is an updated version of the arguments of Augé (1984) – restated by others (Cambrosio, Young, Lock 2000) – in not distinguishing what he called “the anthropology of illness” from social anthropology.

The question in our view is not so much a matter of recognizing a separate identity for this trend in anthropology, which is principally the result of a mobilization of resources and of the actual legitimacy of its agents and institutions. The most important aspect is to acknowledge that an understanding of the realities of health and sickness is essentially based on the interface between human experiences of suffering, provoked by events which affect the biological, existential and social body, and particular socio-political contexts which allow them to be translated into feelings (individual and collective) and into interpretations and explanations (emic and etic). Having said this, the methods of analysis used in anthropology to show the social, cultural and political dimensions behind the phenomena of sickness and health are enormously diverse but undoubtedly complementary. The point where argument arises lies in the ethical horizons and political standpoints which influence those who study the subject in their thematic definitions, theoretical-methodological choices and strategies/tactics of communication and use of results and reflections.

Narratives of origin and national politico-social questions

One of the most frequent narratives of origin is the one that recounts the beginnings of MA in the USA, going back to the 1950s and the efforts of anthropologists such as Georges Foster and Benjamin Paul (Castro, Farmer, 2005). This is explained by various factors, from the fact that that country saw the first attempt at the systematization of this sub-area to its influence on various other countries, by means of the categorization of a significant number of theoretical concepts used in works on the phenomenon of illness, whether in the area of anthropology or in related areas, such as public health, the sociology of health, the psychology

of health, etc. What particularly draws the attention is the organization of this sub-area for strictly practical purposes which, in assisting international public health programs in their need to understand autochthonous cosmologies in order to achieve a better implementation of health education programs, ended by widening the scope of anthropology (Castro, Farmer, 2005) by establishing “the first field of research created and sustained independently” (Leslie, 2001, p.430). As regards the socio-political context, we find references linked to the dominant position of the USA on the world stage and its activities in large development aid projects. Leslie (2001, p.430) stresses that “in the rhetoric of the Cold War, aid to friendly ‘third world’ countries would strengthen their governments and prevent the emergence of revolutionary discontent.” Added to this political dominance was the assumption of the superiority of western science in the fight against health problems in poor countries, mired in “superstitious” local traditions.

This picture starts to change from the 1960s: anthropological practice becomes politicized, in accordance with Marxist or liberal theory, and the “politically correct” label comes into being, which among other things questions the modern/traditional dualism (Leslie, 2001). Since then MA in North America has unquestionably undergone a radical transformation, through an extraordinary enterprise of deconstruction and demystification of biomedicine. This project has produced a critical analysis of the reasoning behind the domination of the medical-scientific field over a variety of traditions and health practices in various parts of the world, has relativized the rational nature of its knowledge, assigning it to specific cultural traditions, and has questioned the supposed neutrality of measures and indicators of effectiveness based on biomedical standards which set out criteria for an “evidence-based approach.”

It may be observed, however, that, from that founding moment which wisely perceived the possibility of cooperation between different areas of knowledge – during a period in which a discourse on interdisciplinary work did not exist – the praxeological nature of that MA survived until more recently, without the overtones of subordination and connivance of the first experiences, but insisting on the importance of a practice which was engaged, collaborative and based on the need to achieve a vision of joint responses between different areas of knowledge (Rossi, 2005; Massé, 2005). Out of this interdisciplinary cooperation arose a vision of an epistemologically unitary fusion of the human sciences as the starting point for an understanding of the phenomena of sickness and health, derived from a systemic approach in which the biological and historical-social aspects “might be examined and interpreted bearing in mind their interactive relationship and at the same time their reciprocal autonomy and specificity” (Seppilli, 2011, p.912).

In other countries with anthropological traditions as vigorous and dominant on the world scene as that of the USA, it is surprising to find that the narrative of the origins of MA is presented in more euphemistic terms that do not make such great claims for special status in the field of anthropology. We refer particularly to France and England as two interesting cases of variations on the narrative. For this purpose, we shall adopt a single point of reference, that of the recognition of MA as a specific field.

In the case of France, the recognition of MA meets resistance from an important writer, Marc Augé. For Augé (1984), what anthropologists note in therapeutic processes (including

the practices of traditional healers) and in cultural interpretations with regard to the genesis of illnesses, guards an indisputable proximity to local theories of power, thereby assuming a strongly political interpretation, and appears as one of the structural pillars of the society. Despite this argument in favor of a holistic understanding of the subject, it is curious to note that Augé does not refrain from giving the name “anthropology of illness” to works of this nature, for which Faizang (2005), underlining this French originality, suggests the status of *appellation d'origine contrôlée*.

In England, perhaps for a similar reason, namely because of the conviction that the field of illness forms part of and nourishes an understanding of the social logic behind cultural practices, another great anthropologist, Victor Turner, as recounted by Frankenberg (2005), resisted writing from this viewpoint. *Lunda medicine, and the treatment of disease*, of 1964, written grudgingly, would have been his only work that could be described as medical. Nevertheless, it was his subsequent experience with the *Ndembu* healing ritual which allowed him to develop his general analysis of ritual liminality, a theory of recognized influence in English MA, as well as on North American authors, as shown by the early works of Byron Good (1977).

There is no doubt that French and English MAs distanced themselves from this aspect with reference to their origins and in practice embraced diverse views and various theoretical influences. They are evidence, however, of the argument that the subject of health/sickness is not always thought to be endowed with a specific nature when it comes to be considered by anthropologists. It is not by chance that, over the course followed by MA, the tendency has been to make use of analyses that are more inter-dimensional, repositioning the object of study in richer, more complex and overlapping environments, in an effort to understand its complex nature. If, for some authors, this may have meant almost a failure to differentiate the subject of health within the total social fabric, for others it has meant recognizing that its analysis lies in the knots woven by the biological, existential, social, cultural and political dimensions which give it its shape.

And what can we say of countries whose anthropologies have traditionally been considered peripheral (Oliveira, 1988)? Despite the specific historical differences, it is noteworthy that one form of narrative repeats itself, insofar as they share either a subordinate position in global politics or conflicting internal questions of identity, to the point that these aspects become the focal point of choice.

In Canada (Bibeau, Graham, Fleising, 2005), MA has its origins in an appeal to national history, in which language, national identity and multiculturalism emerge as the central topics of interest. The identity crisis, which marks the history of the country, is reflected in the absence of an “original Canadian paradigm,” an absence interpreted as a sign of vitality and openness, leading to a greater awareness of the questions posed by society itself. For a long time, Canadian studies centered on the indigenous populations of the country and on migration. With the changes in the global picture, new and important social questions have arisen which have influenced intellectual interests and in large part diversified the subjects of academic study.

In Italy, Pandolfi and Bibeau (2005) have highlighted the important regionalist connotations of MA, characterized by its “strong political coloring” and “socio-political engagement” (p.199)

up to the 1980s, with a heavy theoretical influence from philosophers such as Benedetto Croce and from the Marxism of Antonio Gramsci, linked to a history bedeviled by disputes between the national unification project of the fascists and strong regional cultures, manifested in different spoken languages and important sociocultural differences. Martínez-Hernández (2008, p.165) suggests that the ethnologist Ernesto De Martino has adopted the view of Croce on the pedagogic relationship which is inherent in every hegemonic relationship to guide his interpretation of the world of magic in the lower classes. According to this writer, De Martino undertakes a historical analysis of popular culture that allows him to distinguish it from the interests of the elite, which he defines as the “historicization of the archaic” (p.165). Many of the topics of Italian medical anthropologists, following the example of those developed by Seppilli (1984), pursue the path marked out by De Martino, centered on the cultural world of poor peasants, considered as a symbol of otherness and valued for their potential as regards health education and health promotion.

In Mexico, during the 1960s, anthropologists sought to legitimize MA as a study opposed to the growing medicalization of society. At the end of the 1970s, basing themselves on studies by ethnological historians of indigenous medical thought and on their own studies, writers such as Vargas, Lozoya and Zolla sought to emphasize traditional medicine in the relationships that it establishes with other medical systems, highlighting its practical importance for various sectors of the population. (Castro, 2003). These efforts ran contrary to the role played by the institutionalization of indigenism as a public policy, in the second half of the twentieth century, which prescribed the development of health programs directed towards indigenous peoples, the fruit of the collaboration between anthropology and the biological sciences with the aim of spreading western medical practices which might change the health habits of these peoples (Nigenda, Duarte-Gomez, Navarro, 2005).

It is interesting to note the recognition, by authors such as Martínez-Hernández (2008), of the closeness between Italy’s historical and sociopolitical MA and the MAs developed in Spain and in Mexico, forming a current of thought that he brings together under the title of “peripheral neo-Marxism” (p.162). According to the arguments put forward by this writer, there is a single theory common to these MAs, which leads in the direction advocated more fully by Pizza (2005) regarding the need for MA to engage on a theoretical basis with the writings of Gramsci, whose works would amply demonstrate its vocation towards an “engaged observation” of reality, of the ethnographical type. Pizza identifies in the works of Gramsci “a dramatic and reflective tension” in the subjective process of incorporating the social dialectic, to which is added an acute observation of “the microphysics of social transformation, the hegemony of the State and the individual and collective capacity to act (agency)” (p.17). Gramsci also has the merit of having rescued the importance of corporeality in the works of Marx, which has been neglected by other Marxist authors.

Even though a centrifugal force may be observed in the theoretical influences which connect writers in a number of peripheral MAs to wider international networks, their distinguishing feature of not going beyond national frontiers in their fieldwork is an aspect which, even though on the way towards changing, still distinguishes developing countries. In other words, from the outset they have always been “anthropologies at home.” This characteristic is far from being simply a relic of the first anthropological works. It is still

seen in the contemporary trend, principally in first world countries, towards redefining the objects of study in terms of globalizing or globalized changes, where topics such as north-south and south-south relations, and their reflections in the field of health, such as innovations and transfers of technology in a global context, occupy a very important place in the research agenda for anthropology and the sociology of health (Gaudillière, 2006). This goes back to the national adoption of positions in the game of international politics, drawing our attention to two central points: the unequal visibility and audibility of the various countries in the international intellectual debate and the need for greater democratization of knowledge with regard to current global challenges.

Having said this, we must emphasize the mutual exchanges of concepts, theoretical trends and topics between various countries, even if, on many occasions, concepts stemming from peripheral anthropologies tend to be more widely adopted when they are publicized by writers belonging to the central anthropologies. We see, however, that the national character of medical anthropologies is shown particularly by the social questions and political contexts that surround and influence them, and also by their own styles, and less by the writers and theories that inspire them. Moreover, the great debates and topics of interest are historically dated and globally defined, even though the time they take to reach some countries may be subject to a certain lag owing to the language, access to periodicals, and the internal and external policies for the financial support of science.

The anthropolitics of illness and suffering: some of the great contemporary debates in medical anthropology

Clearly, we do not propose to exhaust the literature of what is in vogue in the research and study agendas of contemporary MA, which would be an impossible task. As we must choose specific themes from an extremely fecund field, we have selected works (articles and chapters of books) which comprise epistemological discussions or which present ethnographies on MA by reference to those aspects which involve a socio-political interpretation of the realities of health/illness, even though based on diverging theoretical standpoints. In an attempt at systematization for the purposes of this article, we shall suggest three main groups: (1) "critical medical anthropology," which is oriented on the basis of a political economy for health (Young, 1976; Waitzkin, 1981; Menéndez, 1981; Navarro, 1985) and focuses on power relationships and the social inequalities associated with illnesses (Farmer, 1992; Wilkinson, 1996); (2) the hermeneutic and phenomenological studies which seek to understand social suffering on the basis of narratives, which we can group together under the name of "the anthropology of suffering" (Kleinman, Lock, Das, 1997; Das et al., 2001); (3) the studies involving the concepts of bio-power, bio-politics and bio-sociality, which are strongly present in the writings of those who work in the fields of bio-science and bio-technology (Rabinow, 1992; Bibeau, Graham, Fleising, 2005).

It is important to note that: (a) considerable interplay can be observed between these three groups, and there are writers whose work can be placed in more than one of the groups; (b) there is no intention to establish a linear chronology between them (it is only in some cases that we can perceive that discussions started by one group have had an influence on other

groups), because many of the debates took place simultaneously; (c) political and social problems do not always characterize all the work of a single author; and (d) inevitably, not all the writers who deal with this topic have been included. Finally, the classification of these three groups has been made for heuristic purposes and will enable us to highlight our central theme.

Critical medical anthropology

In the USA during the 1980s, within a current of thought which styled itself “critical medical anthropology,” some anthropologists started to put forward explanations of the realities of health and illness on the basis of the relationship between capitalism and society, making use of political, social and economic theories of ill health (Martínez-Hernández, 2008). It may be observed that this current of anthropological thought is the outcome of a long tradition in medical social sciences and “social medicine” of investigating the distribution of health services, the part played by power in health care relationships, and the social institutions and inequalities responsible for the distribution of morbidity and mortality rates in society – themes which Arthur Kleinman (apud Good, 1994, p.56) described as the “social production of illness,” as opposed to the “social construction of illness” commonly found in constructivist approaches. Good (1994) attributes to Keesing the origin of this line of thought critical of interpretative anthropology, based on the idea that “[cultures] constitute ideologies, masking human policies and economic realities ... cultures are networks of mystification as much as they are of meaning” (Keesing, 1987, p.161).

In Mexico, it was particularly on the basis of the work of Eduardo Menéndez that this critical trend became preeminent, extending also to Latin America and Spain. One of its important concepts was the “hegemonic medical model” attributed to biomedicine, classifying it as “biologist,” “a-historical,” asocial, individualist and pragmatic (Castro, 2003, p.49). Another fundamental concept, the “social needs of health” (Menéndez, 1981), should be understood on the basis of a “general system of transactions” which the various sections of populations establish between themselves, under the influence of dominant/subordinate relationships. These concepts, expounded at the ideological, social, economic and political level, have been widely made use of in studies on the social production of illnesses, with particular reference to how this system of transactions acts as an obstacle to popular strategies for resistance, and have been seen as notably relevant theoretical tools during periods in which various countries in Latin America have experienced dictatorial political systems.

In the United States, one of the most influential current exponents of this theoretical trend, Paul Farmer, published a seminal work in 1992 in which he launched a plea to researchers to question “culturalist” interpretations for phenomena that have much more obvious explanations if interpreted in the light of the social determinants for illness. According to Farmer (1992, p.111), “to reduce poverty and inequality, the result of a long process of impoverishment, to cultural differences” is a mistaken interpretation which allows the creation of “mystifications” as regards other cultures. Disproportionalities in morbidity and mortality rates, along with various forms of oppression and suffering, are inbuilt in “biosocial realities” which must be viewed through the prism of structural violence, signified on the basis of historical rationales, and which is produced in global mechanisms.

War and the consequences of war, major environmental disasters, the humanitarian aid involved in them, the movement of refugees, and the challenges to public health as a result of such events have also become the subject matter of anthropology. We see, for example, studies that contain important reflections on the political, economic, social and human elements associated with these events, against a backcloth of the various interests and power relationships in globalized world geopolitics (Pandolfi, 2003; Spoljar-Vrzina, 2002). Notable among these, in periodicals of wide international circulation, are articles by native anthropologists, a result made possible by recent discussion, in so-called post-colonial studies, of the importance of ethnographical analyses “from within” (Bhabha, 1997).

From this perspective, Spoljar-Vrzina (2002), who is Croatian, looks at the post-war situation in the former Yugoslavia as regards international aid and the position of refugees, with particular reference to health requirements. The author recognizes the importance of the role played by various anthropologists “from outside” in what she calls the “engaged testimony” of the suffering brought on by the conflict; however, she also discusses more problematical aspects of certain research programs, such as the futility of the obsessive “scientific classification of suffering,” which results in fictitious realities; the dubious value of strategies that are not based on specific demands by the population, but governed by the political strategies of the research funds; and the risk of procedures which “inflict fresh trauma on those already traumatized.” In the context of health, this risk is attributed to humanitarian programs which are ignorant of people’s real health needs, deny their previous history, fail to take account of local institutions – imposing on them technologies which are over-specific and liable to become outdated, often conforming to market interests, or culturally unsuitable – or which take away their right to decide by themselves how to make the best use of the international funds intended to repair the ravages of war.

Away from the area of war and conflict, critical anthropological studies in Europe and North America have also considered the consequences of recent large scale immigration processes in various parts of the world, particularly with regard to its effects on health services and on proposed strategies for health and medical care. A recurrent concern of these studies as to the challenges posed by the complexities of multiculturalism has been increased by a more recent preoccupation with the effects of involvement in problems linked to poverty and social marginalization of large sections of these immigrants, and has produced heated debate over what has been identified as the risk of confounding social conflict with cultural differences. With the intention of providing a critical analysis of current French policy dealing with the so-called “new social questions” (Rosanvallón, 1995), which speaks of a particular kind of “social suffering” identified towards the end of the 20th century, Fassin (2004) examines a rich ethnography on the “listening places” for this suffering, resources developed in France under this policy. Though aware of the value of the work carried out by professionals in those social services, the author points to the tendency to “psychologize” suffering, to the predominance of an ethos of compassion and pacification of marginal areas and of conduct, instead of the development of collective procedures with a view to changing the experience of social inequality and strategies aimed at social justice.

The anthropology of suffering

Inspired by the debate launched by critical medical anthropology, one of the main exponents of the trend known as the “anthropology of experience,” Arthur Kleinman, at the end of the 1990s, coined the term “social suffering” as a key category for the analysis of certain social realities, founding in the process what became known as the “anthropology of suffering” (Kleinman, Lock, Das, 1997). The concept refers to a set of human problems which originate in devastating events, such as war, starvation, depression, produced at the interface of the influence which political, institutional and economic powers exercise over individuals and groups, as well as over the manner in which they respond to these problems.

Kleinman (1995) starts from the idea that the recognition of suffering is a fundamental step towards understanding it, advocating respect for something that disturbs and afflicts the communities studied. He draws attention to the risk that inappropriate classifications, by means of medicalization, or the construction of blueprints or models, dehumanize this suffering by denying its legitimacy and isolating it from its particular moral domain, in an effort to explain or interpret it, resorting very quickly to scientific categories, including those of the social sciences, or to portrayals in the media. To avoid this risk, these studies prioritize ethnographies that are concerned with the inter-subjective fabric of the cultural interpretation of phenomena and with narratives of subjects which relate them to the way in which political questions and social dynamics act inside the societies studied. For Kleinman, understanding what is under threat for the people of a given locality, what represents both danger and the conditions for overcoming it, requires an examination of key ethno-psychological categories and the processes which govern them in practical experience; the human conditions which promote resistance to the development of plans and programs in the daily course of living (shared resistances); and the dialectic between these resistances and the relevant culturally constructed structures.

In the set of essays (Kleinman, Lock, Das, 1997) which launched this concept, a number of writers attempted to translate the experience of social suffering into different cultural contexts. Bowker (1997) seeks, in the religious beliefs of society, explanations for the “presence of evil” (the injustices and social inequalities which might be contained in this emic category), but also concrete solutions. Ramphele (1997), in a study of the “political widows” under apartheid in South Africa, describes the interaction between the body self and the body politic in the dynamic employed, in an attempt to deal with the ambiguity characteristic of this marginal social position and the associated ritual perils. The author admits the limitations to these women’s agency in a society in which gender relationships allow private grief to be homogenized and transformed into stereotyped public mourning, substituting the idolization of the dead man with the idolization of his widow. A similar process is described by Das (1997), who writes of the appropriation of women’s bodies in India as a result of collective tragedies and follows the course of a local moral context in which a “silent death,” conceived as a “bad death,” favors the migration of the pain of that body to the body of another person. Taking this process as a sign of the limited ability of traditional resources to express and represent the pain of grieving, Das concludes that “pain is the means by which society establishes its ownership over individuals” (p.88). Also impelled by a wish

to understand how individuals and groups, through their culture and daily lives, produce tools to deal with and give meaning to painful experiences, Langer (1997) produces a study of Holocaust survivors. Accepting, on the basis of their testimony, that it is not possible to make sense of a situation of such extreme atrocity, and that it is therefore also not possible to be cured of this pain, the author sees the emergence in these reports of expressions of what he calls “permanent time,” on the basis of which the need for an “alarmed view,” which is recurrent in histories of the Holocaust, becomes meaningful.

In 2001, a new collection of ethnographies (Das et al., 2001) revisits the theme of social suffering; the authors are principally concerned with describing the strategies for the reconstruction of experienced atrocities. The narratives refer to turbulent periods of terror or civil war in such different situations as Sri Lanka, Thailand and South Africa, or those resulting from a history of oppression and marginalization, such as those experienced by Canadian Amerindians. For example, Perera (2001) describes situations in Sri Lanka, where mechanisms are employed by means of spiritual possessions and the appearance of avenging ghosts as instruments for recalling and elaborating sufferings. The author analyses these “traditional healing mechanisms” against a backcloth of a society in which civil justice and the rule of law were openly subverted, giving rise to a feeling of disbelief in the punishment of the guilty parties or in the protection of citizens by the state. Adelson (2001) traces the process whereby Canadian Amerindians have tried to reconstruct their identity, which includes what he calls the “re-imagination of aboriginality” as an attempt to produce a social response to the violence they have historically suffered. Aboriginality constitutes a group of histories and actions, a series of fusions between the old and the new, which function as mediators in identity negotiations with the nation state and as a resource for empowerment. This, says the author, if not a cure, may at least be considered a “process of recovery.”

This set of pioneering studies, written towards the end of the 1990s and at the beginning of the twenty-first century, has inspired numerous other contributions, ranging from those concerned with societies in conflict through experiences of war or genocide, or societies marked by urban violence or gender violence, through to more common situations in which feelings of suffering are caused by the experience of social inequalities, discrimination or class conflict. In the field of mental health, there have been an increasing number of studies which identify macro-social situations involving de-regulation and the destabilization of the labor market which, when combined with the hegemony of somatic treatment, the result of market domination by the pharmaceutical industry, function as important barriers to efforts at de-institutionalization undertaken in various national contexts. As a result, we can observe a “new institutionalization, albeit now decentralized, in relation to the chronically sick” (Correa Urquiza et al., 2006, p.54), “confined in the social arena to a non-place” (p.65) and the commodification of suffering (Desviat, 2010). These studies and texts are, in themselves, a response to the demand made with increasing urgency in the field of MA for more political interpretations of social realities, and place in question relationships of power and dominance, human conditions of extreme subjection, and particularly violent structural situations in which individuals feel that their potential for action has been reduced, but which, even so, allow us to draw lessons with regard to human strategies for responding to, or resisting, these extreme situations or the various other situations which produce social suffering.

The anthropology of bio-power

For many years, the politicization of MA was, in a sense, a response to what was considered to be an excessive culturalization of the social processes of illness and human suffering, to criticisms directed at an assumed crystalized concept of culture, but also to what was judged to be a cultural analysis almost always undertaken by an “outsider,” observing peripheral societies which were poor or formerly colonial. For Bibeau, Graham and Fleising (2005), once there had been a cooling off in the period of “cultural wars,” that is to say, the great debates aimed at establishing a historical, practical and political understanding of cultures, a group of writers began to concern themselves with “science wars.” These studies were carried out at the beginning of the present century, principally in the advanced capitalist countries, because “we are living in a period in which bio-politics constitutes the principal strategy employed to maintain post-industrial societies” (p.27). These works, which have gained wide international currency in the field of contemporary MA, progressively becoming global, were basically inspired by concepts such as bio-power (Foucault, 1976), bio-sociality (Rabinow, 1992), and bio-politics, this last term being coined by Margareth Lock “to relate studies in the attribution of meaning to illnesses and in how they challenge the ‘natural’ categories of biomedicine to an examination of the social relationships which produce the forms and distribution of illnesses in societies” (Guarnaccia, 2001, p.427).

This reorientation corresponds to the change in the position of biotechnologies, particularly in first world countries (Lock, Bibeau, 1992), and to the phenomenon of the “geneticization” of society (Lippman, 1991). In a recent lecture (Fendos, 2009), Lock pointed out that the interest of anthropologists in such matters has been growing in proportion to the effects they have started to have on people’s daily lives, whether through the increasing amount of information, particularly in the mainstream media, or because of the social implications of the establishment of genetic profiles, or because of the moral dilemmas posed by the breeding of hybrid plants and animals, raising the possibility of the hybridization of the human species itself: “the advent of the genomic revolution brings with it important societal, political and social questions which have the potential to radically change both life and human interaction” (Fendos, 2009, p.167).

As regards the new advances in genetics, Rayna Rapp (1999, 2000, 2001) has carried out studies of its effects on particular groups, which she calls “technologies in action,” in which observations are recorded of how they are understood, absorbed and, occasionally, refuted. Among other things, the study examined the social impact of pre-natal diagnostic tests, such as that which allows Down’s syndrome to be identified (Rapp, 2000) or detects the gene that indicates achondroplasia (Rapp, 1999). The author produces evidence to show how views on such tests can vary according to the situation of the persons concerned, whether they are persons who feel threatened by such discoveries, such as dwarfs, who say they are “a species in danger of extinction,” or whether they are persons who advocate the termination of pregnancy. For the first group, the phenotypic differences have become normal and have found means of social support, while for the second group, the differences simply mean deficiencies and pathological conditions, and should be eliminated, raising old fears of eugenics and prejudice (Rapp, 2001).

Lock (2000), in her turn, made important contributions to the relationship between cultures and “local biologies,” putting into context the effects of biotechnologies. She shows how different values are capable of molding the ways in which biotechnologies and science are used and represented, illustrating this by the practices with regard to organ donation, accepted in the USA but practically taboo in Japan, which are related to the manner in which human concepts such as the person, birth and death are constructed and experienced.

This illustrates the extent to which science may be viewed as a “question” to be approached by methods of socio-cultural analysis, in the same way as the oracle of the Azande was studied at the time of Evans-Pritchard (Cambrosio, Young, Lock, 2000). Science is also a field of study *par excellence* when the researcher is concerned with the ways in which the body is “politicized,” taking politics to be the mechanisms which combine and go beyond the techniques of the discipline – which affect individual bodies – and the politics of population control (Foucault, 1976), mediated by both the politics of health and by the clinic. Also highlighted are the ways in which patients, families and associated groups have participated in these “politics of life,” contributing towards their management and creating forms of “biosociality,” prefigured by the formation of organized groups based on “new identities and practices” (Rabinow, 1992). In this way, where new diagnoses have emerged, people have learned to deal with them and manage them for their own benefit, as in the cases examined by Dumit (2006) with regard to Chronic Fatigue Syndrome and other “emerging illnesses.”

Final considerations: from the politics of interpretation to the politics of reaction

A study of historical forms of consciousness (Comaroff, Comaroff, 1987), as shown through the different expressions of the imagination and of human experiences, molded through the intervention of cultural forms, has been one of the tasks undertaken by anthropologists in their ethnographic strategies. This analytical exercise, combining methodological rigor and interpretative creativity, has produced texts that bring original and consistent insights into what is involved in the infinitesimal forms through which concrete realities of health and sickness are produced and structured, showing or concealing social distinctions, relationships of domination, economic inequalities and political interests. A reading of some of these texts, by confronting us with the realities of war, terror, exclusion and violence, tends to produce in us feelings of unease, horror and indignation, combined with an urge to act. Others, by placing naturalized realities in parentheses, thereby making it possible to deconstruct them by revealing the dynamics and the social and political networks that produce them, provide material for reflection. However, by interpreting other societies on the basis of these thematic and theoretical choices, anthropology not only allows us access to their *modus operandi* as regards the intersections which govern the social, cultural and political aspects of societies; it confronts us with its potential for revelation. In this way, it presents us with a challenge for reflection, where the power of revelation is placed at the interface between the personal choices of authors, collective peer movements, and historical demands.

The course taken by MA is a paradigmatic example of the trends in an area that raises questions with regard to the frontiers within its own field and outside it. Within its field, the highlights have been the great debates that have launched it on a journey to politicize its

analyses of the realities of health and sickness. As a consequence, we have seen a great increase in studies which show that power and domination games can develop into unaccustomed realities, but that, in some societies, these games occur in a more unequal and oppressive way. Outside its field, there is recognition that the objects of its study give it a privileged position in terms of wider analyses of the social order, and a consciousness that the complexity of its subject matter requires interdisciplinary interpretation; moreover, that it is necessary to combine exposure and accusation with something else, namely engagement and action. Some viewpoints give greater emphasis to this requirement in their rhetoric, when they set out projects for the transformation of situations encountered in their studies. It is undeniable, however, that this aim has been pursued by all parties, when we note the ethics of implication which orients ethnographies engaging anthropologists with hard realities over long periods of time and which is expressed in their critical reading of local or global situations where hegemonies are well established.

This inward and outward movement can also be observed when the factors shaping the course of MA are directly linked to historical contexts and national and international politics. In this sense, politics are decisive in defining the field, and this becomes clear both from the construction of the narratives of origin and the still unequal positions that the various national anthropologies occupy today on the geopolitical scene, their ability to be heard (including the question of language) and their influence, all of which are connected to matters such as financing, the potential for the internationalization of their discoveries, and the defining of research agendas.

NOTE

¹ In this and other citations from non-English languages, a free translation has been provided.

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