AM
Rivista della Società italiana di antropologia medica / 11-12, ottobre 2001, pp. 41-60

Contributions and challenges of Medical Anthropology to Anthropology.

Integration of multiple dimensions of social suffering and medicalization of Medical Anthropology

Raymond Massé

Département of Anthropology, Laval University (Québec City, Canada)

Introduction: importance of medical anthropology as a sub-discipline

Medical anthropology has become one of the most prominent sub-disciplines in anthropology. The significant number of graduate students, research programs and researchers it attracts, as well as the credibility it has acquired as an applied science in national and international health development programs, has given credibility to the discipline among social scientists as well as among managers in public institutions.

The reasons for the success of this sub-discipline are numerous. In developed countries, the 1980's were marked by the emergence of problems which revealed determining social and cultural factors related to health problems (AIDS, drug addiction, teenage pregnancy, eating disorders), and dramatic changes in consumer confidence in biomedicine. In particular, the twin epidemics of AIDS and substance abuse that mushroomed in the 1980's urgently called for a participation of anthropologists in multidisciplinary public health teams. On the international scene, anthropologists were invited to play a significant role in the planning and the evaluation of programs related to diarrhoeal disease, tropical diseases or AIDS. The topical breadth of contributions of medical anthropology to the socio-cultural analysis of infectious diseases (Inhorn and Brown, 1997), or to public health programs (Halm, 1999) have been abundantly debated.

It seems obvious that one of the first contributions of medical anthropology to anthropology is the popularisation of the anthropological discipline

among the administrators of public institutions, other social science disciplines and the general public. More than any other sub-discipline, medical anthropology will contribute to position anthropology as a major discipline among social sciences. Anthropology is no longer seen as a fundamental field of research on exotic cultures or minority cultures in pluriethnic societies. From now on, it will be known to the general public as an applied social science applicable to the solution of concrete problems. Associated to "soft" methodologies, henceforth, it will be known as an innovative discipline in qualitative methodologies and as a discipline known for its flexibility (for example: *Rapid Ethnographic Assessment Methodology*). The image of the isolated individualistic field anthropologist will be replaced by the image of a helpful and credible anthropologist as part of multidisciplinary teams.

In brief, medical anthropology, more than any other sub-discipline, will contribute to building a scientific credibility and a positive social image of anthropology. This new credibility will open the doors for anthropologists to national institutions of public health (i.e. *Centre for Disease Control*, public health administrations, community health programs) and numerous international public and private organisations, working in public health. This relative abundance of employment offers for medical anthropologists, coupled with the intrinsic appeal of a sub-discipline which harmonises practice and theory, will ensure that the student clientele of Anglo-Saxon university departments of anthropology will stabilise and, possibly, even increase. Furthermore, the European counterpart will experience the same trend.

Contributions to classic fields of research in anthropology

Of course, contributions of medical anthropology are not only restricted to this marketing function, which has established the credibility and the popularity of anthropology. Fundamentally, it has allowed a deeper analysis to be made of several fields of classic research in anthropology. We will only give some examples here.

1) Medical anthropology has allowed the confirmation of the importance of the holistic approach, which is systemic in anthropology. Since the classic works of Clements (1932) and Rivers (1924), ethnomedicine has become one of the essential dimensions of culture to be investigated. As suggested by Rubel and Hass, in a functionalist perspective, "one of the most prominent ways in which ethnomedicine contributed to the development of theory and method in socio-cultural an-

thropology was to show the functional integration of the components of health care institutions within society's cultural matrix, its social organisation, or political system" (Rubel and Hass, 1990; 116).

2) Through its analyses of the introduction of biomedicine in traditional societies, medical anthropology has become one of the most privileged fields of studies of acculturation mechanisms and local reinterpretation processes of knowledge and foreign practices. The anthropology of biomedicine is becoming a privileged research field of sub-development and of the globalisation phenomenon through the study of internationalisation processes of knowledge and biomedical care practices.

3) Ethnomedicine studies will become one of the privileged fields for the analysis of alternatives to biomedicine and strategies of local resistances to new forms of powers, namely the ones associated to biopower in a critical anthropological perspective (Baer, Singer & Susser, 1997, Berche, 1; 1999).

In fact, the list could be longer to cover more or less all the problems covered by modern anthropology (feminist studies, immigration, identity, cultural and ethical relativism, public policies and so on), all the problems which have been discussed, more precisely, by means of studies on health and disease.

Production of new concepts and theories

The contributions of medical anthropology are not limited to dynamisation and the renewal of the research traditionally associated to anthropology. Questioning the role of cultural and social factors in the analysis of the causes of disease and its unequal distribution through time and space has contributed to the renewal of ecological and theoretical models on the role of environment and to a reorientation of traditional physical anthropology. The analysis of the socio-cultural construction of illness has stimulated the refinement of the cognitive and interpretative theoretical models. In the early 1970s, in reaction to criticism of its lack of theorisation and a descriptive tendency, the sub-discipline shifted ground. «The 1980s were a time of ferment in academia, marked by debates between advocates of critical theory, feminism, and postmodernism; [...] studies of cultural knowledge structures and embodied knowledge; [...] a time of theory posturing» recalls Nichter (1991:1). Many important concepts, models and theories were suggested that focused on either the semiotic and interpretative (i.e. concepts of idioms of distress, semantic networks, the illness explanatory model), economic-political (theories on resistance or biopower in critical medical anthropology), or phenomenological (i.e. concepts of existential fields of illness, embodiment) dimensions of the illness experi-

ence. The production and refinement of these concepts and theories can be seen as one of the most important contributions that medical anthropology has made to the discipline.

However, in the next pages, I will put emphasis on what I consider the two major challenges which medical anthropology will have to face in the coming years. In my opinion, these challenges must be faced by the discipline of anthropology as a whole. If medical anthropology succeeds in taking up these challenges it will have significantly contributed to the evolution of anthropology as a social science, as much on the theoretical level as on the level of applied anthropology. The first challenge is the articulation between the multiple dimensions of the illness experience. More specifically, and this difficulty is a challenge for all of the sub-disciplines in anthropology, the theoretical endeavour will have to bear on the analysis of the interrelationship between three dimensions of illness: The *individual dimension* (1), the *socio-cultural dimension* (2), and the *economic-political dimension* (3). The theoretical challenge is that of complementarity between phenomenological, interpretative and critical perspectives, and that of the articulation between micro and macro-analysis. The second challenge is that of denaturalising the anthropological in medical anthropology, through the menace of a medicalization of anthropology. If medical anthropology has contributed to the renewal and to the dynamisation of research in several classic problems in anthropology, if it has promoted the development of concepts and theoretical models that have enriched the parent discipline, an excessive medicalization of medical anthropology could also have negative impacts on anthropology. If it permits anthropology to consolidate its scientific credibility and gain prestige in the competitive field of social sciences, a possible denaturalisation of medical anthropology risks denaturalising anthropology itself. Insofar as it will be able to accept these two challenges, medical anthropology will contribute to discussions on the nature and the place of anthropology in the field of social sciences.

The challenge of the commensurability of phenomenal, interpretativist and critical analysis of illness

Few concepts and theories have been dedicated to the explanation of the inter-relationship of the illness experience with the multiple dimensions of reality and the interface between the multiple layers of the illness experience. Yet, I think, it is at this level that the major challenge exists for

contemporary medical anthropology. We will briefly summarise these concepts and theories in three approaches that now coexist within the discipline.

– *Ethnographic works which have described folk beliefs associated with nature and illness causes, beliefs conceived as being organised in coherent systems.* This approach, described by Good (1994) as empiricist, by default considers beliefs as well-defined statement, easily identifiable concrete entities, which are, therefore, modifiable by health education programs. Such a reification of both beliefs and culture considered as a cultural system has been attractive for those health professionals looking for concrete cultural targets for public health programs and for those relying on psychosocial predictive models such as the Health Belief Model (see Massé, 1995.130-141). This empiricist paradigm is also based on "rationalist theories of medical beliefs, the ecological theories of ethnomedical systems as essentially adaptive and analytic primacy of choice in studies of illness behaviour" (Good, 1994.44).

– *The analysis of illness representations as culturally constituted realities.* Illness is no more seen as a biological entity but as a semantic network, an idiom of distress or an explanatory model. This approach has sensitised health professionals to the importance of a cultural construction analysis concerning the meaning of illness for a given population. It favoured an analysis of popular symbolic structures and processes through which illness is linked to fundamental cultural values.

– *The Anglo-Saxon critical medical anthropology* is characterised by emphasis on the structural, political and economic causes of illness, the asymmetric power relations (gender, ethnic, class) which characterise practitioner-patient relations and the reproduction methods of the hegemonic position of biomedicine in comparison with ethnomedicines. It pays particular attention to the influence of the world economic and political system on the distribution of illness and care (Frankenberg, 1980, Baer, Singer and Susser, 1997). This approach postulates that the principal, but latent, function of ill being medicalization, would be the resolution of social conflicts (Swann, 1989:1169) giving advantage to dominant economic and political classes.

In its response to these biomedical and cultural deviations, critical medical anthropology divides itself into two tendencies. Firstly, a political economy which focus its attention on a macro-analysis of the effects of international policies on health causes and treatment. This approach, which is considered as the missing link of medical anthropology (Morsy, 1979), puts the emphasis on the link between local socio-cultural dynamics and historically determined national, international, political and economic processes (Morsy, 1996). It dedicates dependency relations between rich and poor countries (Morgan, 1987). Secondly, a critical interpretative anthropology (Lock and Scheper-Hughes, 1996), which resembles a radical phenomenological approach. For Lock and Scheper-Hughes (1996), the meaning of suffering continuously evolves to the confluence of the three bodies. That is to say, under the influence of lived experience by the person (*em-*

bodiment in individual body), the symbolic representations held by the society (*social body*) and the political control and discipline of individuals (*body politic*).

In our opinion, the issue that constitutes one of the major challenges of medical anthropology at the beginning of the 21st century, is one of the articulations between these interpretative and critical perspectives. If the approach of radical phenomenology advocated by Nancy Scheper-Hughes, among others, partially succeeds in conciliating explanation and interpretation of illness, the political economy approach of health keeps us away from such an arrangement. This approach was criticised (Morgan, 1987), among other things, for an excessive transcultural application of Western concepts about gender and class relations, and for the evacuation of ethnomedicine as a form of local resistance to biomedical hegemony or as the expression of creativity of dominated cultures. The absence of analysis of economic development impacts on the population's health. However, it is not easy to achieve this complementarity of approaches without falling into the trap of over-determining the meaning of suffering and delegitimizing discourses and local methods of health taken in charge (Kleinman, 1992).

This challenge of objectively reconciling the international political and economic macrostructure and the analysis of local health interpretations – a priori a difficult task – requires the articulation among various health relations to be modelled. Singer and Baer (1995) have proposed a model for analysing behaviours linked to health, integrating four levels from a macro-social level. They refer to the world capitalist system, to international economic corporations and institutions. However, they include: A social intermediary level, which reveals the role of biomedical and ethnomedical care institutions. A micro social level, which reveals interactions between patients and medicine-men, and finally an individual level linked to relations that an individual maintains with his social network, his lived illness experiences and his personal psychological and physical system. Bibeau (1996) proposes a three dimensional analysis model, which puts the emphasis on interfaces between the macro-sociological forces that determine the semiologic patterning of reality, the historical context and power relations. In this context, cultural values have been developed. However, the model takes mediating categories into consideration. The cultural codes are articulated to the macro-social context and to the usage people make of it during their daily experience. The new medical anthropology will be constructed, according to Bibeau, on the clarification of intermediary levels between outside forces and local socio-cultural organisations, and on

the analysis of the interfaces between the multiple dimensions of reality in order to make a comprehensive conceptual framework that bridges the gaps created by the tendency to counterbalance the post-modern-literary and politico-economic drifts in anthropology. Anthropology should remember its ultimate goal and mission, which is to produce a comprehensive, multidimensional, encompassing interpretation of human experiences in a world in constant evolution.

However, although the theoretical importance of combining these various interpretative and critical levels of analysis is commonly recognized, the ethnographic works published in medical anthropology do not do so, or even attempt to do so [(4)]. The challenge that must be faced, then, is that of an interpretative anthropology of suffering, sensitive to the historic local and individual consequences and to its economic and symbolic power relations (Farmer, 1988:80). In particular, I believe that the concept of social suffering makes such a contribution. In the context of a quest for a comprehensive framework this concept could bridge the gaps between these multiple readings of reality. It would also deepen the analysis of the interconnectedness among political-economic, socio-cultural and phenomenological dimensions of suffering. This is what I have tried to explain in a recent paper (Massé, 2001), by describing the outlines of a critical ethnoepidemiology of social suffering in the French Caribbean based on the explicit goal of complementarity between phenomenological, interpretative and economic and political perspectives.

We are conscious that such a challenge is at the very heart of the whole discipline of anthropology (and maybe of all social sciences), in particular in the issues of economic globalisation, post colonialism and sub-development. However, we also believe that this challenge concentrates on the health and illness field. If it is obvious that social and economic inequalities, as much on a national as on an international level, explain the over exposure of some populations to risk factors and unhealthy living conditions. Then, it is also true that the illness experience is a privileged field of study of the role of cognitive and symbolic structures in the socio-cultural construction of meaning and the domain of deeply intimate human experience. Must we renounce this challenge and conclude that these levels of analysis are incommensurable? Or must we make it one of the conditions of the evolution of medical anthropology and of the whole discipline? I believe, for my part, that medical anthropology has no other choice than accept the challenge. To confine oneself to the analysis of health cultural representations is to condemn oneself to the marginal status of cultural fact specialists and to the label of exotic specialist. By changing for a polit-

ical economy of health, you condemn yourself to managing without the expertise of the fieldwork and of the emic analysis of illness interpretations and experiences. Anthropology has no other choice but to return to its preoccupation with a comprehensive understanding of disease. However, two related challenges will have to be accepted if we wish to conciliate these multiple analysis levels: the redefinition of the notion of context and the abuse in the anthropological interpretation of illness experiences.

The concept of context

The definition of context, which has to delimit the perimeters of the anthropologic fields, is becoming increasingly complicated. The exotic ground is not the only pertinent study framework in the context of the globalisation; it is the whole planet, which gives a meaning to local ground. However, an anthropology of globalisation must not move the anthropologist away from his concern for local culture. Nor he must not practice an anthropology "at home". Returning home must be a step to an expansion, a release from the inside, a project which must be guided by the observation of world history which is now taking place world-wide (Copans, 2000: 31). Do the internationalisation of fieldwork via an anthropology of internationalisation and the fallback position on an anthropology at home constitute the two opposite dimensions of a single phenomenon of relocation of anthropology? These are some of the related issues that raise the question of the context of analysis.

In the framework of a vigorous defence for a return to what is unique in ethnographic methods – their reflexivity, which gives subjects the authority to determine the contexts of their beliefs and practices –, Englund and Leach (2000: 225) are afraid that the cult of meta-narratives of modernity in contemporary anthropology give anthropologists readymade speeches on the largest context or the local context. As Gupta (2000: 240) underlines: «The central point here is that one cannot assume, as anthropologists have been wont to do, that the local is its own universe, a geographically circumscribed space where meanings are made, where the most important social interactions occur, where economic and affective life is lived, and where social structures are reproduced». The fundamental question here, in the analysis of ethnomedicines and local reinterpretations of biomedical knowledge and practices, as Appadurai (1996) says, is the following: does the larger-scale perspective yield more knowledge about the narrower context than the focus on the local context itself? I agree with Abelès (1996) that «anthropology must be careful in its dealings with the fetishist trap of the microanalysis, and not accept at face value the illusion that

proximity generates, quasi mechanically, a better knowledge of the object» (Abelès, 1996:99). Deconstruction of macro-analytic categories risks condemning ourselves to an epistemological powerlessness. On the other hand, macro-analytic generalisation approaches, and the resort to reified models and concepts, are responsible for oversimplifications, which have serious ideological and political consequences (Lévi, 1996:188). Personally speaking, I believe that, in medical anthropology as well as in the anthropology of other modernity problems, we should look for a mid-term between macro-analysis of the 'world-system' and the classic analysis of exotic local ethnomedicine. The 'ethnography of middle-range' suggested by Comaroff (1993) seems to be a reassuring alternative here. However, it entails a deconstruction of the concept of context itself. We do not say that a wider context does not exist, but we suggest that anthropology should find a middle-way between inductive, emic approaches based on the micro-analysis of meaning constructions and lived experience and macro-analysis using deductive approaches through concepts and theories that reflect preconceived views. The risk is to be disengaged from a 'reflexive knowledge production'.

The abuse of interpretation

In fact, beyond the definition of an intermediary level of analysis between micro and macro society, the question posed by these meta-narratives of modernity is that of over-determination of the meaning of illness or, more precisely, that of imposition of analysis charts (concepts, theories) outside local realities interpreted by the anthropologist. Examples range from the efforts of Horton to demonstrate the rationality, and even scientificalness, of magical practices, to the comments of Comaroff (1993) on the fundamentally 'magical' bases of beliefs and practices in Western modernity.

The concept of 'resistance' is one of those theoretical categories that are candidates for the status of total deconstruction of illness. For Kleinman it refers to «resisting the imposition of dominating definitions (diagnoses), norms defining how we should behave (prescriptions), and official accounts (records) of what has happened. We resist, in the micro political structure, oppressive relationships. Such resistance may take the form of active struggle against dominant forces or a more passive form of non-compliance» (Kleinman, 1995: 126). As applied to human suffering and to ethnomedicines defined as local forms of resistance to the globalisation of biomedical care, techniques, and values, this concept gives primacy to the search for political meaning over intersubjective and situational meaning with the experience of suffering.

> «The interpretative requirements of suffering for theodicy – namely, the struggle of rebuilding a coherent account of why misery should exist in the world –, are viewed by many anthropologists as the core reality of suffering. [But] the intersubjective experience of suffering is so various, so multileveled, so open to original inventions, that interpreting it solely as an existential quest for meaning, or as disguised popular critique of dominant ideology, notwithstanding the moral resonance of those foci, is inadequate. It may distort this most deeply human conditions» (Kleinman, 2000:145).

In such a perspective, Englund and Leach (2000) denounce the dangers associated with the meta-narratives of modernity such as those of individualisation, multiple modernity, and ruptures between tradition and modernity. For example, to see the belief in the healing powers of the Holy Spirit among Pentecostalists, or the beliefs in the evil nature of 'black people's medicine' as part of the global counter-movement against 'disenchantment' subordinates the ethnographic data to interpretation «guided by a pre-given meta-narrative rather than close attention to the interaction between the ethnographer and his or her interlocutors in the production of anthropological knowledge» (Englund and Leach, 2000:236). We agree with Sabgren that these theories of renunciation «contribute to locating all effective historical agency or causation in metaphysically conceived wider forces like 'individualisation', 'commodification' and 'globalisation'. This essentialisation of what constitutes the anthropologically 'relevant' becomes not only a cover for 'ethnographic ignorance' as they argue, but also (it seems to me) a warrant for theoretical ignorance» (Sangren, 2000:243). Therefore, medical anthropology will have to be careful with concepts and meta-narratives which incorrectly simplify the lived complexity of illness and do violence to the personally idiosyncratic and situationally particular.

The challenge of the non medicalization of the anthropology of health

Another contribution of medical anthropology to anthropology is, in my point of view, a reminder of the risk of disciplinary dissolution and denaturalisation, in the context of abusive and clumsy borrowing from other social science approaches to human experience. This contribution can be illustrated by analysing the tendency toward a "medicalization of medical anthropology" that characterises Anglo-Saxon anthropology.

In the 1970's and 1980's, a certain passion for finding new places for complementarity between anthropology and epidemiology surfaced. The objective was to propose methods, which allowed the prevalence of health problems to be measured, particularly mental health, and to analyse their

distribution through time and space. The epistemological issue had just found a middle-ground position between the universal pretensions of the occidental psychiatric nosographies and the documentation of culture-bound syndromes that referred to sicknesses specific to certain cultures. In both cases (as in several other fields of application of health anthropology) anthropologists associated with cultural factor specialities were encouraged to intervene to facilitate biomedical interventions, improve results and facilitate expansion. Evidently, criticism came swiftly from anthropologists sensitive to the ethical issues masked by such collaboration. Several reminded the anthropologists that the application of medical anthropology could not support the imperialist enterprise of biomedicine, which was both cultural and economic; nor could it accept the folklorization or the marginalisation of ethnomedicine. Nancy Scheper-Hughes, for example (1990: 192), called for a medical anthropology that must obligatorily «disengage itself with regards to medicine and demarcate itself from conventional biomedical interests». The issue here is that of the risks of anthropological biomedicalisation, in particular of mental health or, more precisely, the risks of subordinating the possible contributions of Anthropology to the epistemological postulates and the agenda of Medicine.

Such a warning against the medicalization of anthropology was recently voiced by the American Carole Browner (1999), who perceives a strong tendency among anthropologists to retain biomedical entities conceptualized by medicine as objects of research. She sees in this a form of anthropological acculturation which she describes as "going native", that is, becoming "medical natives" by adopting the language and the scientific practices, in short, the scientific culture. What I am advancing here is that the risks of medicalizing health anthropology must be analysed on two levels. Firstly, on the epistemological level, the level of the risks of empiricist deviation through the abusive usage of diagnostic categories in the definition of the sickness. And, secondly, on the methodological level, through recourse to qualitative methodologies borrowed from social science which tend to marginalise the field approach.

The risks of deviation towards an empiricist epistemology: the example of the abuse of psychiatric diagnostic categories

A reading of the recent issues in the major medical anthropological journals, particularly Anglo-Saxon ones, attests to a certain withdrawal of anthropologists from illnesses as biomedical diagnostic entities. On the physical level, there is a plethora of articles dealing with respiratory and urinary troubles, cancer, menopause, AIDS and so on. On the level of mental

health, papers deal with Alzheimer, depression, schizophrenia, pre-menstrual syndrome or post-traumatic stress. These illnesses are becoming the starting point for analyses aimed at identifying the cultural dimensions linked by each culture to these medical diagnostic entities**.** The risk of medicalizing anthropology is that of reorienting research on diagnostic categories and seeing diseases as reified nosographies delimitable and definable by means of symptomatologic configurations. In other words, there is a risk of an empiricist drift.

From this standpoint, retaining "folk illnesses" or "culture-bound syndromes" as objects of research does not constitute an alternative to this empiricism. It only renews the perspective which confines psychological problems to reified categories (this time by means of popular knowledge) which is always defined according to somatic, affective, cognitive, or behavioural manifestations.

In 1989, Mirowski and Ross severely criticised the use made by epidemiology and psychiatry in particular of diagnostic categories, as is the case with the DSM or the CIMIO. They maintained that having recourse to diagnostics such as mental health measurement tools hinders an in-depth comprehension of the manifestations and the causes of psychological problems largely because diagnostics do not take into account the structure of the relationships of causality which link the variables. This report groups the causes, the symptoms, the consequences and the random associations existing between the symptoms into one shapeless mass (Myrowski and Ross, 1989:19). Byron Good (1992), for his part, criticises the diagnostic categories because they consider the disorderly categories as tangible and mutually exclusive discrete entities but disregard the logic of classification based on the nuances and of gradations based on the distress level and the severity of symptoms or causes.

However, psychiatric anthropology's response to this risk of empiricist drift does not constitute a true epistemological break. Kleinman (1997) suggests that psychiatric anthropology make a critical analysis of the nosographic classifications of universal pretensions. Furthermore, he recommends that psychiatric anthropology open itself to a 'creolization' of psychiatric practices or a 'colonisation' of psychiatric diagnoses by way of an open discussion on cultural pluralism. Therefore, the issue would be to reaffirm the importance of «projecting the local amid the global while taking very seriously into consideration the local terms for disease identification» (Kleinman, 1997:75). Thus, in our opinion, to the extent that the focus is the categorical classification of sickness, even if it integrates some

local cultural components, it is still a form of subordination of anthropology to epistemology and to the agenda of psychiatry. Although this objective is very commendable and most certainly inevitable it must not, however, summarize the essential components of anthropology to the analysis of mental illness.

From this same perspective, another path of major collaboration between anthropology and psychiatry is that of the promotion of sensitivity to DSM-IV with regards to the influence of culture on categorisations of mental "disorders". In the introduction to Volume 35 (3) 1998 of the journal *Transcultural Psychiatry*, Laurence Kirmayer writes a rather negative assessment about the results of the work group on *Culture and Diagnostic*. Although anthropological research presents popular parallel nosographies and even local idioms through which different peoples express and explain the numerous forms of mental health, the work group responsible for the DSM-IV only includes the following elements in the final version: a brief commentary on the importance of culture, some sections about cultural considerations, age and gender which accompany the texts linked to certain psychiatric categories, an annexed glossary containing some 25 culturally conditioned syndromes and a user's guide for the formulation of the cultural conditions of a diagnosis.

The introduction to the summary volume for the DSM-IV did not take into account the suggestion of integrating a definition of culture, race and ethnicity prepared for this purpose. No room was allotted for constructive criticism which stated that the division in cathegories of somatoformic, affective, distress and dissociative disorders did not respect the natural covariations of the forms of distress which were observed in trans-cultural studies. Throughout the manual, culture was presented as a bias capable of leading one to erroneous diagnoses, rather than as a component of the definition of mental illness as a construction that is as cultural as it is professional. There was a brief outline of the cultural formulation of psychiatric disorders but it was an annex and not placed directly after the introduction to underline the importance of taking cultural and social contexts into account.

Evidently, communication between psychiatrists specialising in epidemiology and anthropologists required them to share at least a common language. This common language was that of empiricism where all concerned looked for recurrent characteristics and patterns founded on reified symptoms for the purpose of defining pathological entities, and describing and delimiting disorders. Here again, the price that anthropologists pay is the

risk of losing sight of what constitutes their originality and their strength: that is, the analysis of the influence of individual, social and political contexts of suffering. Such collaborations risk marginalizing anthropology of the experience of suffering, individually lived but socially, politically and culturally built. In fact, the leitmotif of psychiatric anthropology over the last two decades has been to criticise the validity of the diagnostic categories while the task of epidemiology has been to increase reliability. While the DSM's working groups' papers aimed to ensure the internal coherence of the criteria of diagnostic definitions (e.g. the stability of factorial constructs between one social sub-group and culture and another), anthropology questioned the validity of the established roles and categories. But even this critical approach confirms anthropology's subordination to the medical agenda. Paradoxically, it strengthens the epistemological paradigm that it believes it is denouncing.

Methodology and field work

The medicalisation of anthropology, a trend confirmed in the specialised journals (see infra. Hadolt), expresses itself either through interviews, sometimes completed by direct observations done in decontextualized sites (operating rooms, hospital emergency waiting rooms), or through methodologies based on narratives of lived episodes of sickness. In the 1980s, health practitioners called upon anthropologists to develop rapid ethnographic assessment procedures to assist them in the collection of data related to knowledge, beliefs, and values about diseases. Generally, we note the absence of long-term fieldwork, and also the absence of narratives being integrated into social and global political contexts.

Let's be clear here. Such new data analysis methodologies as iterative content analysis, discourse analysis or grounded theory, as well as the increasing use of analytic textual data software, represent a jump-start for anthropology. Not only do I personally teach them in my department but also I have also widely used them within the framework of different research projects in Quebec. I consider that these methods and techniques help to reinforce the validity and credibility of research in the anthropology of health and to make the construction of conclusions less impressionistic, more explicit and more systematic. Far from renouncing these methods, anthropology, like all the other social sciences, should draw inspiration from them**.** However, the price to pay may be too high. Anthropology risks losing sight of the discipline's global perspective, which depends on contextualizing the steps of sickness in the social, political, economical and global cultural framework. In fact, the fundamental issue here is that of a

marginalisation of the terrain of the anthropology of health. Englund and Leach state that the biggest threat to anthropology is not the problem of funding but «the factory conditions and audit practices which now structure the academic work» (2000: 238), as well as the pressure to feed the proliferation of journals, book series, and conferences. This does not fit in with the reflection of "a slow and unpredictable activity by its very nature". «Under such conditions, the doctoral project is becoming the only period of sustained and long-term fieldwork in a scholarly career. Not surprisingly, perspectives which require a minimum of fieldwork, perspectives which demand instant ethnography to illustrate aspects of a metropolitan meta-narrative, hold increasing appeal» (Englund and Leach, 2000: 238-39). Hence, the recourse to meta-narratives and vast theorisations of post-modernism serves as an alternative to a "realist reflective ethnography", which rests on a real commitment, founded on the experience that the researcher shares with the local population.

Two tendencies counterbalance this move toward the marginalization of the field and the decontextualisation of analysis. First of all, we can note with Kleinman (1995) a return to an in-depth ethnography in medical anthropology's publications. There have been more detailed monographs published in book form since the end of the 1980s than in the previous forty years. There seems to be a pendulum effect in the publication of hundreds of essentially theoretical studies. Kleinman (1995:194-197) sees that these ethnographic monographs challenge the basic conventions of health research. In the depth of their analysis, their attention to detail, and their sensitivity to the plurality of constructions of the significance of sickness, ethnographic books are an alternative, which is situated in a no man's land between science and humanities. But foremost, ethnographic books provide the most faithful representation possible of the phenomena that are marginalised by medicine, such as common knowledge, alternative practices, the phenomenological dimensions of the experience of sickness, and the socio-political causes of sickness. At the beginning of the 1970s, an important phenomenological current began to develop in Anglo-Saxon medical anthropology around the ethnographic concept of the real life experience of suffering and sickness. This is an important contribution that risked a methodological drift, which could have led to the decontextualisation of sickness from the biographic framework in which it exists. In this last example, however, there is always the risk of confining the analysis of social and mental suffering to the macro level.

In the framework of my own research on psychological distress in Martinique and in French Canada (Québec), I had initially planned to produce

diagnostic tools that were sensitive to local idioms of identification, expression and explanation of mental suffering. I could have done this using case studies of depressed patients, open interviews with sick people or with people close to the patient, or diagnostic charts to which a few 'local' symptoms would have been added. However, each of these approaches restricts the analysis to a person outside the context of the family, community and social surroundings in which he is evolving. Only a hands-on, long term approach, built on observations of the different life surroundings where this psychological distress develops, allows us to grasp the work of culture on suffering and to grasp the richness of meanings brought out by the local idioms used to describe distress. For example, the observation of constant tension between spouses, between parents and children, between grand-parents and grand-children have confirmed that, while it is sometimes a nest of security and stability, the family environment is the first place where stress, anxiety and frustrations burst out. In a Caribbean context, an anthropology of depression has a lot in common with the family and inter-family relationships, marked by an accelerated destructuralisation of the family and the difficult relationships between the traditional Caribbean man and the new Caribbean woman. Also, anthropology of social suffering must take into consideration different mediatorial observation spaces. For example, political assemblies or unions are extremely interesting surroundings in which to analyse the social and racial tensions that serve as a backdrop to a tense and frustrating climate. Small group meetings and prayer meetings organised by the members of Fundamentalist churches, which take place in the homes of sick brothers and sisters, allow us to explain the importance of the church as a place for rebuilding lives and overcoming depression. An analysis of the pastor's sermons allows us to understand the place that Satan and sin occupy in the people's explanation of sickness. It also allows us to understand the origin of many sick people's re-interpretation of alcoholism and drug abuse, as well as dancing and sexual liberation as demonic manifestations that bring depression. Just as important are the direct observations of suffering within the daily life of unemployed people who wander around the capital's streets or tourist beaches, or the analysis of what is conveyed in the newspapers, radio, television, political assemblies, and which it is possible to understand with a sustained fieldwork approach.

There is no need to lengthen such a list with more examples for an audience of anthropologists. However, the present pressure for an applied anthropology, which is complementary to medicine, reminds us of the importance of being sensitive to the social life of individuals on whose behalf anthropologists want to express themselves. The contributions of Anthro-

pology must go beyond the framework of a culturalisation of diagnostic categories, be they popular or medical, which will include different forms of expressing psychological distress.

Conclusion

This tendency to medicalise the anthropology of health is seen to be more significant in Anglo-Saxon countries than in France and Europe in general. The reasons are complex. In the United States, Canada and Australia, in particular, not only has this sub-discipline been established since the beginning of the 1980's, but also in the last two decades, several thousand graduates in medical anthropology have found jobs in governmental agencies, community health centres, multiethnic organisations, public health agencies, research centres in epidemiology, insurance companies, and in other institutions far removed from the preoccupations of fundamental research. In no way do I believe that we must refute this tendency towards tangible and practical applications of anthropological knowledge to Health Care and to the management of health policies. Having myself worked for several years as an anthropologist within a governmental agency of public health, I can attest to the importance and to the pertinence of such a contribution. However, it is clear that an applied medical anthropology will not be able to maintain its credibility unless it is systematically nourished by sustained fieldwork that allows the inter-relationship between diverse illness dimensions to be analysed. These risks are linked to the reification of diagnostic categories, to the division of social and cultural factors and to their division in decontexualized variables that conceal the influence of economic and political structures.

In fact, what I have dealt with in this presentation are the limits of complementarity between medicine and anthropology and, more particularly, the incommensurability between these radically different perspectives. I maintain that even though medical anthropology and medicine (or epidemiology) share the same concerns methodologically and epistemologically speaking, they are nonetheless perfectly incommensurable ontologically speaking, be it on the level of the target objectives, or in the ultimate finalities. There is incommensurability between the finalities of comprehension and the objectives of health measurement; between the objectives of reconstructing the numerous layers of the meanings of suffering and the objectives of producing culturally adapted definitions of illness categories which will serve as a springboard to comparative transcultural investigations. Fi-

nally between the objectives of relocating meaning in the numerous levels of context versus the objectives of delimiting diagnostic entities by presenting transcontextual validity.

The search for zones of complementarity between, on the one hand, an anthropology of health and, on the other hand, epidemiology, medicine and psychiatry must remain a major anthropological challenge during the coming decades. Increased rigor in qualitative research methods, the development of a common epistemological vocabulary and the search for common methodological ground between these approaches is a necessary, but not sufficient, condition. Anthropology must, however, assume the responsibility that it is radically marked out on an epistemological and ontological level both in regards to fundamental beliefs about the nature of the reality studied and in regards to the ultimate finality of the research (Massé 2000). It will have to assume without complexes and in a creative way the incomensurability of ontological paradigms.

Notes

(1) The individual dimension is related to an analysis of the daily personal experience of illness and of the physical and social environment in which the disease is experienced.

(2) The socio-cultural dimension refers to the sociological and cultural characteristics of the society and the ethnic group concerned.

(3) The economic-political dimension refers to the organisation of the care system, to political causes concerning inequality in care and health, to asymmetric power relations between caregivers, administrators and patients and between rich and poor countries.

(4) We can mention some examples such as Kleinman (1986) on the social origin of distress in China, or Farmer (1996) who, in his study on Aids in Haiti, calls for an anthropology which will go beyond the search for cultural meaning, the eternal object of research on ideas and symbols. This anthropology will see that AIDS in Haiti is clearly in keeping with a political and economic crisis which is itself rooted in the social and economic structures inherited from the colonial time.

References

Abelès, M. (1996) "Le rationalisme à l'épreuve". In Revel, J. (ed.) *Jeux d'échelles. La micro-analyse à l'expérience*. Paris: Gallimard; Le Seuil. (Hautes Études) p. 95-112.

Appadurai, A. (1996) *Modernity at large: Cultural dimensions of globalization*. Minneapolis: University of Minissota Press.

Baer, H. A.; Singer M. and I. Susser (1997) *Medical Anthropology and the world system. A critical perspective*. Westport, Conn.: Bergin and Garvey.

Bibeau, G. (1996) "A Step toward Thick Thinking: From Webs of Significance to connections across dimensions". *Medical Anthropology Quarterly*, vol. 10, num. 4, p. 402-416.

Berche, T. (1999) *Anthropologie et santé publique en pays Dogon*. Paris: Éditions Karthala.

Browner, C. H. (1999) "On the Medicalization of Medical Anthropology". *Medical Anthropology Quarterly*, vol. 13, num. 2, p. 135-140.

Clements Forest, E. (1932) "Primitive Concepts of disease". *University of California Publications in american Archeology and Ethnology*, vol. 32, num. 2, p. 185-252.

Comaroff, J. and J. Comaroff (1993) "Introduction". In Comaroff, J. and J. Comaroff (eds.) *Modernity and its malcontents: Ritual and Power in postcolonial Africa*. Chicago: Universty of Chicago Press.

Copans, J. (2000) "Mondialisation des terrains ou internationalisation des traditions disciplinaires? L'utopie d'une anthropologie sans frontières". *Anthropologie et Sociétés*, vol. 24, num. 1, p. 21-42

De Swaan, A. (1989) "The reluctant imperialism of the medical profession". *Social Science and Medicine*, vol. 28, p. 1165-1170.

Englund, H. and J. Leach (2000) "Ethnography and the Meta-Narratives of Modernity". *Current Anthropology*, vol. 41, num. 2, p. 225-239.

Farmer, P. (1992, 1996) *Sida en Haïti. La victime accusée*. Paris: Khartala.

Frankenberg, R. (1980) "Medical anthropology and development: A theoretical perspective". *Social Science and Medicine*, vol. 14B, p. 197-207.

Good, B. (1992) "Culture and Psychopathology: Directions for Psychiatric anthropology". In Schwartz, T.; Wshite, G. M. and C. A. Lutz (dirs.) *New Directions in Psychological anthropology*. Cambridge: Cambridge University Press.

Good, B. (1994) *Medicine, rationality and experience. An anthropological perspective*. New York: Cambridge University Press.

Gupta, A. (2000) "Comments (on Englund and Leach paper)". *Current Anthropology*, vol. 41, num. 2, p. 240-241.

Hahn, R. (ed.) (1999) *Anthropology in Public Health. Bridging Differenceds in Culture and Society*. New York; Oxford: Oxford University Press.

Inhorn, M. C. and P. J. Brown (eds.) (1997) *The anthropology of Infectious Disease. International Health Perspectives*. Amsterdam: Gordon and Breach publishers.

Kleinman, A. (1995) *Writing at the margin. Discourse between Anthropology and Medicien*. Berkeley: University of California Press.

Kleinman, A. (1997) "On Gilles Bibeau's Creolizing World". *Transcultural Psychiatry,* vol. 34, num. 1, p. 72-77.

Kirmayer, L. (1998) "The fate of Culture in DSM-IV"». *Transcultural Psychiatry*, vol. 35, num. 3, p. 339-342.

Levi, G. (1996) "Comportements, ressources, procès: avant la 'révolution' de la consommation". In Revel, J. (ed.) *Jeux d'échelles. La micro-analyse à l'expérience*. Paris: Gallimard; Le Seuil. (Hautes Études) p. 187-208.

Lock, M. and N. Scheper-Hughes (1996) "A Critical-Interpretative Approach in Medical Anthropology: Rituals and Routines in Discipline and Dissent". In Johnson, T. M. and C. F. Sargent (eds.) *Medical anthropology. Contemporary theory and method.* 2nd ed. New York: Praeger, p. 41-70.

Massé, R. (1995) *Culture et santé publique. Les contributions de l'anthropologie à la prévention et à la promotion de la santé*. Boucherville, Canada: Gaetan Morin Editeurs.

Massé, R. (2000) "Qualitative and Quantitative Analyses of Psychological Distress: Methodological Complementarity and Ontological Incommensurability". *Qualitative Health Research,* vol. 10, num. 3, p. 411-423.

Massé, R. (2001) "Pour une ethnoépidémiologie critique de la détresse psychologique à la Martinique". *Sciences Sociales et Santé*, (in press).

Mirowski, J. and C. E. Ross (1989) "Psychiatric Diagnostic as Reified Measurement". *Journal of Health and Social Behaviour*, vol. 30, p. 11-25.

Morgan, Lynn M. (1987) "Dependency Theory in the Political Economy of Health. An anthropological critique". *Medical Anthropology Quaterly*, vol. 1, num. 2, p. 131-155.

Morsy, S. (1979) "The Missing Link in Medical Anthropology: The Political Economy of Health". *Reviews in Anthropology*, vol. 6, p. 349-363.

Morsy, S. (1996) "Political Economy in Medical Anthropology". In Johnson, T. M. and C.F. Sargent (eds.) *Medical Anthropology: Contemporary theory and Method*. 2nd ed. New York: Praeger, p. 21-40.

Nichter, M. (1991) "Preface". In Hill, C. E. (ed.) *Training Manual in Applied Medical Anthropology*. Washington, D. C.: American Anthropological Association, p. 1-13. (Special Publication of the American Anthropological Association; 27).

Nichter, M. and M. Nichter (1986) "Health Education by appropriate analogy: Using the familiar to explain the New". *Convergence*, vol. XIX, num. 1, p. 63-71.

Rivers, W. H. R. (1924) *Medicine, Magic, and Religion*. London; Kegan, Paul, Gtrench, Trubner and Co.

Rubel, A. J. and M. R. Hass (1990) "Ethnomedicine". In Johnson, T. M. and C. F. Sargent (eds.) *Medical Anthropology. Contemporary Theory and Method*. New York: Praeger. p. 115-131.

Sangren, P. S. (2000) "Comments (on Englund and Leach paper)". *Current Anthropology*, vol. 41, num. 2, p. 243-44.

Scheper-Hughes, N. (1990) "Three propositions for a critically applied medical anthropology". *Social Science and Medicine*, vol. 30, num. 2, p. 189-197.

Singer, M. and H. Baer (eds.) (1995) *Critical Medical Anthropology*. Amityville: Baywood Pub.