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Symptoms, epistemes *and poaching anthropologists*

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Despite the great diversity of theoretical approaches, ethnographic orientations and specialities in contemporary anthropology, nowadays many things seem to be becoming homogenous and recurrent in our field. One of them, perhaps the most evident, is the continuous conquest of new fields of research. In a short time, topics of interest, which would have been strange to our ethnographic gaze just a few years ago, have become the usual subjects of everyday anthropological writing. This phenomenon has probably been more pronounced in the anthropological specialities which have developed over the last thirty years. Obviously, creating a new speciality always involves an effort of scientific imagination to delimit the borders and belongings of the new territory. For instance, in medical anthropology it is well known that after an intellectual struggle with Western scientific medical tradition diseases, therapies, symptoms, syndromes and even biomedical knowledge have become objects of critical reflection and ethnographic analysis.

Nevertheless, anthropologists have not reflected about the way some topics become relevant to our own "scientific culture". We have, in this scepticism of reason that is post-modern American anthropology, good (and now classic) examples of reflexivity about ethnographic encounter (Crapanzano 1980; Rabinow 1977) and ethnographic authority (Clifford 1983). We have, in contemporary anthropology, interesting incursions into the study of reason, rationality and science (Lock and Gordon 1988; Rabinow 1996) and also good historiographical and genealogical accounts of past theories and practices in our own discipline (like Stocking's books). However, we do not have the routine of self-reflection about how we incorporate new subjects and what epistemological or ideological conditions are necessary for this kind of activity.

In this paper I analyse the way medical anthropology began to study the subject of symptom approximately twenty years ago. In spite of focusing on this particular subject, however, my intention here is more general and theoretical and I do not limit myself exclusively to the field of medical anthropology.

The anthropology of symptom and the symptom of anthropology

That symptom is a relevant object of study for medicine, psychiatry and even psychology is an unquestionable fact. Behind a symptom we expect a pathophysiological or psychopathological reality, natural evil in its wide variety of manifestations. However, in the last twenty years symptom has also become a subject of research for some specialities, such as medical anthropology, which are not directly involved in the clinical intercourse. In a short time, what traditionally had been understood to be a pathophysiological, or at least a psychopathological, reality has been understood to be a cultural manifestation, a highly suggestive metaphor, a symbol which condenses social and political-economic contradictions. I believe that in spite of the disparity of opinions in medical anthropology most authors will agree with this, from Byron Good and Mary-Jo DelVecchio Good (1981:165) to Margaret Lock (1991:87), from Arthur Kleinman (1988a: 10) to Scheper-Hughes (1992:181), from Mariella Pandolfi (1990:255) to the caustic Michael Taussig (1980:3).

Anthropological attention to this new object can in turn be interpreted as another example of the discursive indeterminacy that characterises the refiguration of social thought so neatly captured in Geertz' concept of "blurred genres". Suddenly, literary critics are writing about anthropology (Clifford 1983) and anthropologists are behaving as literary critics (Geertz 1988), not to repeat the entire litany of examples of blurred genres cited by Geertz. It even seems that this phenomenon has also affected medical anthropology. What is Kleinman – an anthropologist who talks about medicine, a psychiatrist or a physician? What does Good do – a semeiology of symptoms, an anthropology of affliction, a critique of biomedicine? What is Taussig – an anthropologist, a physician or a reader fascinated by the works of Benjamin and Luckács? What is more, could not the fact that anthropologists interpret symptoms be understood as a new "symptom", but this time of anthropological knowledge itself?

Certainly, we are faced with a continuous, maybe chronic, refiguration of established authorial definitions and of the limits of anthropological knowl-

edge. As well as the traditional subjects there now seem to be new potential worlds of ethnographic practice and speculative thought. Geertz evoked this phenomenon when he pointed out the relevance of Kluckhohn's affirmation that «anthropology is an intellectual poaching license» (1983: 21).

But intellectual poaching activities are never accidental facts. They depend on specific predispositions and "conditions of possibility" of the branch of knowledge in which the "captured" topics are to be implemented. In other words, there are no poaching activities without the epistemological conditions that make it possible for anthropologists to go hunting in new intellectual territories.

Canguilhem teaches us something in this respect. He tells us that the exchange of ideas between scientific specialities – and I say exchange so as not to abuse cynegetic metaphors – is a more frequent phenomenon than the traditional distance between specialities suggests. For instance, the history of the concept of "biologic regulation" in the 18th and 19th centuries is also the history of the relationship between theology, astronomy, medicine and even Comtean sociology. Moreover, the emergence of bacteriological theories and their therapeutic applications in the 19th century is indebted to the development of chemistry and the chemical industry:

> «C'est l'extension des examens microscopiques de préparations cellulaires et la pratique des decolorations à base de derivés synthétiques de l'aniline, industriellement fabriqués en Allemagne à partir de 1870, qui devaient aboutir, pour la première fois dans l'histoire de la mèdecine, à une thérapeutique aussi efficace que libre de toute théorie médicale, la chimiothérapie, inventée par Paul Erhlich (1854-1915)». (Canguilhem 1993:69) (1)

Subsequently Canguilhem points out: *Pas de chimiothérapie sans une certaine société scientifique, sans une certaine société industrielle* (1993: 72), and also no chemotherapy without the scientific view moving from the simple idea of "extraction" of substances to the idea of the massive and industrial "production" of these substances (1993: 72). The emergence of chemotherapy owes more to synthetic aniline stains than Lévi-Strauss to structural linguistics or Clifford Geertz to European hermeneutic philosophy.

Canguilhem builds up an epistemological method, which is useful for analysing the process of appropriation of ideas. This method oscillates between astonishment and perplexity at scientific loans and the study of the "conditions of possibility" of scientific knowledge. It also finds in the "concept" the main referent for relating loans to epistemological conditions. But a concept is not a word. A word can cover different concepts. A concept is a notion that suggests a particular problem in the framework of a science. Defining a con-

cept, therefore, involves delimiting a problem (Canguilhem 1955:5-7, 1989:177; Lecourt 1971:XV). But that's not all. A concept can only be introduced into an intellectual or scientific context if it is coherent with and relevant to existing concepts, theories and hypotheses in this context.

In *La formation du concept de réflexe aux XVII^e^ et XVIII^e^ siècles* Canguilhem shows in an exemplary fashion the potential of his conceptual epistemology. He proves that the traditional common sense that attributes the paternity of the reflex concept in medicine to Descartes is only an illusion. The French epistemologist shows how in Descartes' works the nervous system was understood only in one potential direction: from the centre to the periphery and not from the periphery to the centre. On the contrary, the notion of reflex in modern medicine involves the possibility of both directions: from centre to periphery, but also from periphery to centre. So this evidence clearly invalidates Descartes' claim to the paternity of the medical concept of reflex. In fact, only when physiology was able to understand that the relationship between centre and periphery in the nervous system was double faced, could the concept of reflex be introduced in Western medicine. This was a medical appropriation of the optical idea of light reflection that was made possible by a curious medical identification between life and light (Canguilhem 1955: 51-96).

In short, Canguilhem's studies show that anthropologists are not the only poachers in the intellectual domain and, also, that this kind of activity cannot be undertaken without previous epistemological conditions. Neither is it absurd to think that we can apply the epistemological and conceptual approach that Canguilhem developed for the study of biological sciences to our field; for instance, the appropriation of the concept of symptom by medical anthropology.

The concept: signs versus symptoms

Most medical dictionaries provide a single, well-known distinction between two terms: sign and symptom. The former is usually understood to be objective evidence of disease that can be perceived by a professional. The latter, on the other hand, is understood to be a more ambiguous, uncertain manifestation derived from the perception and expression of the patient themselves. Stone (1988), for example, gives the following definition in his *American Psychiatric Glossary*:

> «Sign: objective evidence of disease or disorder. See also symptom.»

And:

> «Symptom: A specific manifestation of a patient, condition indicative of an abnormal or mental state or a subjective perception of illness.»

It should be noted that "sign" and "symptom", in their most divergent senses, denote completely different orders of reality. Signs, as defined in psychiatric and biomedical terminology, are closely connected to what has been understood in semiotics as indices or natural signals. In the same way that we infer the presence of fire when we see smoke, disease can also be inferred from medical signs such as fever. Neither fever nor smoke (at least not usually in the latter case) is a meaningful creation based on semiotic or cultural conventions; rather, they are both natural occurrences. Signs, then, are characteristically a part of a natural and self-evident reality which, like the tip of an iceberg, only enter the domain of semiosis or signification to the extent that they are interpreted, as a particular disease is inferred from the presence of fever.

In contrast, symptoms refer to a "patient's self-report," to "a subjective perception." Without going any deeper into what is meant here by the word "subjective," we can say that symptoms are the patient's interpretation of a series of bodily, psychic and emotional sensations: "I've got a headache," "I feel depressed," "I'm a bundle of nerves". Symptoms are thus verbalised or mimed and, therefore, their construction reflects the expressive needs of the speaker. So they arise not as part of a physical reality or the visible effect of a cause, but as a human expression or complaint that embodies meaning.

There is a world of difference between a case of eczema and a statement such as "My heart is upset." It is no accident that symptoms have constituted a problem of immense proportions in psychiatry and medicine. Eczema is always eczema, but a complaint of heart distress is not the same when expressed by an Iranian woman, a character in a European romantic novel, a patient from Barcelona with coronary heart disease, or a Nahuatl native from Hueyapan. For the Iranian woman, the heart is a physiological organ that is vulnerable to the oppression of daily life and the problems of feminine sexuality (Good 1977: 41-51). For others, however, it may be the (symbolic) centre of emotional life (romantic characters), an organ that does not function as it should (Barcelona patient), or an organ necessary for the digestion of food (the Nahuatls) (Alvarez 1987: 89-90) [(2)].

The distinction between sign and symptom is of greater importance in clinical knowledge and practice than has generally been recognised. Psychoanalysis, for example, has even semioticized some physical signs; that

is to say, what at first seemed to be a sign is understood as a symptom. Here I am thinking of the meaning of "simulation of childbirth" which Freud attributes to Dora's fever and perityphlitis in *Fragments of an Analysis of a Case of Hysteria* (1988:87). I am also thinking of Freud and Breuer's interpretation of Anna O's *tussis nervosa* in *Studies of Hysteria* (Breuer and Freud 1985: 48). It is even reasonable to state that any psychoanalyst will understand both fever and eczema to be something more than mere pathophysiological signs [(3)]. Nevertheless, contemporary psychiatry and biomedicine have more often than not adopted the opposite view. That is to say, symptoms are objectified as if they were physical signs that bespeak a natural, universal and biographical reality

A few years ago Stanley Jackson pointed out the problems generated by this biomedical orientation in a penetrating paper entitled *The Listening Healer in the History of Psychological Healing* (1992). After enumerating the successes in molecular biology, pharmacology and medical technology during the previous years, Jackson argues that, paradoxically, this success is distancing health professionals from their patients. As he says: «While seeing more we [they] are often at risk of hearing less» (1992: 1630).

The hegemony of seeing over hearing is not new in Western medical tradition but is reminiscent of the origins of modern medicine or biomedicine. For instance, in *Naissance de la clinique*, Foucault shows how modern medicine arose from what he defines as a modification of the clinical gaze. The turning point that gave rise to positivistic medicine is revealed by comparing Pomme [(4)] and Bayle's descriptions [(5)]. In a span of less than 100 years, medical science underwent such a transformation that the quasi-botanical classification of disease entities was overturned by this penetration into the interior of the body. The resulting reorganisation of medical knowledge replaced the old «botany of symptoms» with a new «grammar of signs», the prior emphasis on nosological classification with a study of the sequence of events which give rise to diseases, and the pre-modern doctor's first question – «What is the matter with you?» – With «Where does it hurt?» (1972:XIV)

The features outlined by Foucault in his description of the newly formed "positive medicine" can be found in the characteristics of contemporary biomedicine. If this emergent science was still a long way from Henle-Köch's bacteriological paradigm, which provides Western medicine with a model for understanding and eradicating infectious diseases, and from the clinical experimentation method introduced in 1865 by Claude Bernard, it was nonetheless very close to achieving the epistemological conditions that would bring it into being through Bichat's work in pathology

and Broussais' physiological approach (Laín Entralgo 1947; Canguilhem 1966; López Piñero 1985). Neo-Hippocratic medicine was already being transformed into a science capable of identifying pathological processes through the penetration of the physician's gaze into the silent and natural universe of the organs.

At first, the paradigm of the clinical gaze was to be the dissection of cadavers, but subsequently there were innovations such as the introduction of radiological examination and laboratory tests at the beginning of the century (Jackson, 1992). The ability to localise abnormality would establish the pre-eminence of seeing over hearing and, as a result, the analysis of the signs of disease over the interpretation of symptoms. This is the hallmark of a fully formed biomedical model from which, as we can deduce from Jackson's words, we have not yet emerged.

The role of the symptom in this positivistic and biomedical *episteme* is certainly curious. The medical definition of symptom refers to a reality that is not physical but cultural and linguistic. It is, also, non-specific from the point of view of its localisation in the body, because the patient's complaint is not in itself pathologic. With some exceptions, like aphasia or delusion, the pathological dimension is not part of the discourse, but part of the object that this discourse refers to. For this reason, it is first necessary to interpret the patient's code, the native or emic sense that will indicate the pathological dimension.

It seems that interpretation of patient complaints turns into a necessary activity for the clinician. The symptom's cultural context needs to be taken into account if potential misreadings in the clinical activity are to be avoided. Nevertheless, the history of symptom in biomedical knowledge is clearly the history of a recurrent misreading due to the omission of the meaningful dimension of illness [(6)]. The predominance of seeing over hearing in clinical activity has led to this kind of situation.

At first glance, the predominance of sign over symptom in biomedical knowledge may not seem to be relevant to anthropological interest. We may even think that this subject is more exotic than those that created the original anthropological concern are. How can the fact that biomedicine does not take symptom into account affect anthropology? What is the importance of the biomedical process of reifying symptoms and affliction? The biomedical reification of illness complaints seems to be tangential to theoretical anthropology and ethnographic knowledge. However, it is also true that the anthropological appropriation of the concept of symptom is largely due to the vacuum produced by a medical gaze that ignores dis-

course and focuses on a world of bones, viscera's and pathophysiological realities. In fact, one of the more effective strategies in contemporary medical anthropology is to demonstrate how illness complaints condense a local world of meanings, values and political and economic processes. And this supposes not only that symptom is appropriated but also that it is reformulated. For instance, in anthropology, the relation of symptom to pathological reality is clearly irrelevant. If there is something that clearly separates the anthropological from the biomedical view of symptoms it is precisely the absence or presence of criteria for distinguishing the normal from the pathological.

But neither conceptual appropriation nor conceptual transformation would be possible without certain epistemological conditions of possibility. As Foucault states in *Les mots et les choses* (1966), the *episteme* not only creates the limits of possibility of our knowledge but also the sense of coherence between the new subjects and the old. And even though an *episteme* can introduce coherence between the more disparate elements it also can deny the most "obvious" relationship.[7] For this reason, we must ask ourselves not only about the vacuums in biomedical knowledge, but also about the epistemological modifications that have led to symptom being introduced into medical anthropology as a concept and as a relevant subject.

Epistemological conditions: from behaviours to meanings

In the same paper where Geertz evokes the idea that anthropology is an intellectual poaching license, he also talks about one thing he thinks is true in contemporary social science. I am referring to the well-known assertion that:

> «Many social scientists have turned away from a laws and instances ideal of explanation toward a cases and interpretations one, looking less for the sort that connects planets and pendulums and more for the sort that connects chrysanthemums and swords.» (1983: 19)

This statement is quite a good definition of one of the most polemical epistemological changes in anthropological knowledge: the shift from the dream of a scientific explanation (*Erklären*) of culture and society to an interpretative research of senses and meanings (*Verstehen*). And this epistemological change has also affected the way medical anthropologists understand their work.

Since the seventies, and in spite of the diversity of approaches in contemporary medical anthropology [(8)], we can speak about an interpretative an-

thropology of illness, which, with greater or lesser critical intent, has approached symptoms as expressive forms that reflect local worlds of meaning [9]. The ethnographic task here has been to gain access to the cultural domain within which illness and symptoms are experienced, understood, and interpreted. This approach clearly reflects the influences of European hermeneutic philosophy (Gadamer 1960, Ricoeur 1969) as well as those of the leading authors of the symbolic and interpretative cultural anthropology of the 1960s and 1970s such as Victor Turner and Clifford Geertz. But we can still say something else on the subject: only when anthropology developed an interest in "meanings" and "significations" did the concept of symptom acquire anthropological relevance. But let us begin at the beginning.

Ethnography I: behaviours

In 1964 Philip Newman [10] described with considerable precision the behaviour of an individual suffering from "wild man" – also known as *Wild pig*, *AhaDe idzi Be* or *longlong* – among the Gururumba of New Guinea (1964).

Gambiri, the name by which Newman calls the person in question, had refused to give food to the children who were playing in the village. As the ethnographer had observed many times previously, this was a game of demands and negotiations characterised by the insistence of the youngsters and the apparently patient and calm response of the adult. However, this daily scene gradually began to acquire a strange tone. Gambiri wanted to be given back a bowl that one of the children had snatched from him and, clearly mistaken, accused the ethnographer of having taken it. Then, Gambiri found a plastic pot used as a toilet by the ethnographer's children and said, «There is my bowl. I can take it and throw it away in the forest. It is not heavy». Gambiri's sentence contained a conventionalised message: the moral career of the wild man had begun.

While Newman watched, the villagers began to gather around Gambiri, saying, «*Gambiri ahaDe idzi Be* Gambiri has turned into a wild man». To the ethnographer, this situation seemed to be not unlike a theatrical production in which the actor plays his part and the audience hangs on his every word and gesture. Apparently, however, the relation between actor and audience was in this case even closer. Newman writes, «When Gambiri made threatening gestures toward them they ran off laughing or screaming in mock terror» (1964: 2). In one of these intermittent and contrived rushes, the wild man managed to grab hold of a young girl and take a net bag that

she was carrying. Then, in the ethnographer's words:

> «Gambiri sat down on the ground, removed the contents of the bag, found a piece of soap, which he gave to an onlooker, and a small knife, which he gave to me, saying that it had been given to him by an Australian Patrol Officer for being a good worker on the government road. After gathering up the contents of the bag he then made a series of demands on me, asking for a loin cloth, a tin of meat, and some tobacco. Each denial was answered with a shouted "Maski" [Neo-Melanesian for 'no']... This particular episode was ended when he again accused me of stealing his bowl and was then told by an onlooker that a young boy who happened to be passing by at the moment had taken it. The onlooker also suggested that Gambiri ought to shoot the boy, a suggestion he took up with gusto as he put an arrow to his bow and ran after the intended victim.» (1964: 3)

Following the account of this performance, Newman describes Gambiri's subsequent behaviour during the following two weeks: he visited nearby villages where he stole a number of small items, which he considered to be gifts from imaginary people. He was always aggressive and defiant. He shot arrows at people who were too far away to be wounded. He collected numerous objects, he travelled to more distant villages which did not belong to the area of his own subclan; he disappeared into the jungle, where he scattered the objects he had acquired; and finally he returned to the village and, surprisingly, to everyday normality. His extensive repertoire of "bizarre", strange behaviours were also, nevertheless, conventionalised forms of deviation which enable Newman to speak of a wild man pattern among the Gururumba.

Newman's description is not new. The ethnopsychiatric literature is full of references to deviant behaviours, patterns of misconduct, folk mental illnesses, culture-bound syndromes or similar phenomena otherwise named. However, some elements of Newman's description and analysis of the wild man are particularly striking. At first, the wild man process is initiated with a phrase which is complemented with a «*Gambiri ahaDe idzi Be*» from the onlookers. This sets off a whole chain of behaviours, forms of expression and attitudes, which the ethnographer reconstructs, focusing especially on the analysis of behaviour and behavioural sequences. Although present in Newman's description and analysis, Gururumba forms of expression are clearly of secondary importance compared to Gambiri's behaviour: the collection of objects, petty thefts, return to the village, etc. Newman's article emphasises these behaviours at the expense of Gururumba discourse. Ethnographic observation seems to be more important than listening to his informants. The transcription of behaviour emerges, then, as paramount, and the words of the actor and his audience are relegated to a merely supporting role when the wild man disturbs the calm of village life

(which is not, however, without its tensions). Newman rarely analyses the complaints and questions that are the wild man's typical forms of expression, but focuses primarily on the behaviours and behavioural sequences that take place in a perfectly orchestrated fashion for 16 days. In short, the message of Newman's ethnography is that the principal object of study is behaviour. This behavioural focus is so all-consuming that it tends to behaviouralise the game of questions and answers; that is to say, local discourse.

In Newman's analysis, behaviour is seen as the result of a combination of social, cultural and psychological determinants. Newman traces this idea back to North American Culturalism, acknowledging his intellectual debt to Kluckhohn's analysis of Navajo witchcraft (Newman, 1964:8). The author thus places himself in the Culturalist tradition, although this does not prevent him from asserting that the case of the wild man, like any other deviant behaviour, is not only the mechanical result of "culture using man" but also of "man using culture". What is of interest here is that the reciprocal relation established by the author between the categories of "culture" and "the individual" is determined by the dynamics of the interaction between cultural patterns and behaviour.

Newman reconstructs the complexity of the cultural system in which the action unfolds. In great detail he describes the obligations of a Gururumba married couple, he speaks of the social pressure on thirty-year-old males (who are also the individuals affected by the wild man syndrome) and of their desire to acquire power and prestige. Gambiri, he says, is in an awkward situation: he hasn't paid the bride price and the deadline has been and gone. What is more, his wife is expecting their second child and he will soon have to remunerate his affines for the new offspring in accordance with the traditional obligations of the Gururumba. Gambiri's outburst, therefore, seems to be the result of exogenous, but extremely powerful, forces which overwhelm his capacity of absorption: he only has one pig with which to pay off his increasing debt.

The ethnographic description of the wild man belongs to the anthropological strategy that seeks to locate the essential element of observation – here Gambiri's bizarre behaviour –, in a socio-cultural context that provides meaning and enables an explanation (in its sense of natural explanation), by means of a holistic reconstruction of the situations. At the time in which Newman was writing there was a tradition which endorsed his procedure, as well as a set of key words or concepts which gave meaning to these ethnographic descriptions which were not limited to translating but also attempted to provide an explanation of what was happening. Benedict had

already located the criteria for abnormality in the context of culture in her controversial *Patterns of Culture* (1934). Boas (the last Boas) had already defined a model in which concepts such as individual, culture and behaviour were essential to the anthropological task. As Boas stated, it was:

> «A vain effort to search for sociological laws disregarding what should be called social psychology, namely, the reaction of the individual to culture. They can be no more than empty formulas that can be imbued with life only by taking account of individual behaviour in cultural settings.» (Boas 1966: 258-9)

This was a preview of the interests of the Culture and Personality School, from Benedict to Linton and from Mead to Kardiner: the relation between culture and individual through the duality cultural pattern vs. behaviour; the importance of psychological and psychoanalytical theories and the attempt to explain culture by means of a processual approach that is not based on a historical dimension, but on this constant feedback by which individual behaviours reproduce traditional guidelines through the so called process of socialisation. Briefly, this is what Newman understands as the process of culture using man.

Although Newman attempts to find a cultural and psychological explanation for the wild man behaviour, in the final analysis he can only suggest some relationships between cultural patterns, social conditions and psychological structures. The reason is that it is difficult to answer the question, "Why do some individuals within a group opt for this sort of behaviour and others do not?" It may be thought that social pressure is more intense in some cases than in others or that there are some situations that are more inclined to trigger the wild man pattern. However, the final answer to this question belongs to a dimension that is a feature of the temperament, constitution, hypothetical intrapsychic conflicts or previous characteristics of the personality of the affected individuals. The Culturalist and behaviourist model seems to be at full stretch here: it introduces the reproduction of the context and of the variables that interact but it scarcely mentions the possibility that the phenomenon can be completely explained.

But what is interesting here is that within Newman's theoretical and ethnographic approach the notion of symptom has neither a sense of coherence nor a sense of relevance. In fact, Newman does not use the concept of symptom but other concepts, such as "behaviour", "function", "cultural patterns" or "bizarre behaviour patterns", which are coherent with and relevant to the culturalism of the age.

This is not to say that the word *symptom* was not used on occasion in ethnographies from Newman's time. Some studies from the sixties spoke

specifically about *symptoms* (see Parker 1962: 62; Schooler and Caudill 1964: 172). In these cases, the term is neither a construction of meaning nor an anthropological notion. In Seymour Parker's study of Inuit psychopathology, two years before the publication of Newman's work, the author states:

> «Symptoms will be viewed not simply as a reflection of socio-environmental pressures, but as they function in the personality and social systems in which they appear.» (Parker 1962: 76)

"Function" and "personality" emerge here as key elements to which another extremely important variable must be added: "social systems". What exactly does Parker understand by symptoms? And what do other authors such as Schooler and Caudill understand by symptom in their well-known comparative study of the symptomatology of Japanese and North American schizophrenic patients (1964: 172)?

When these authors use the term *symptom*, they have in mind a conventional psychiatric category in use at the time. Thus Parker says, «the most frequent psychopathological symptoms are morbid depressions, anorexia, and obsessive and paranoid ideation» (1962: 77). In Schooler and Caudill's case, the word *symptoms* refers to "withdrawn", "sleep disturbance", "emotionally labile", "euphoria", "apathy", etc. (1964: 173). That is to say, symptoms are neither constructions of meaning nor forms of expression used by the patient, but psychiatric and biomedical generalisations. There is no conceptual reformulation or emic analysis of symptoms, only a dovetailing of disciplinary interests. Here symptoms have no meaning.

Ethnography II: meanings

Almost thirty years after Newman described the behaviour of the Gururumba wild man, Etsuko Matsuoka (1991) approached a case of *Kitsune-Tsuki* (fox possession) in Japan in a markedly different manner.

Michiko, Matsuoka's informant, began to hear strange voices after the death of her parents. These became more frequent after she visited the "spiritual mountain" where she had attempted to communicate with them through a shaman. The voices became so insistent and loud that she sought help at a psychiatric hospital. However, her seven-month stay in the hospital did not solve her problem because, according to Michiko, «the medicine was no help, but it's natural that spirits can't be cured by medicine and doctors would never understand spirit possession» (1991: 456).

Subsequently, Michiko turned to several different shamans – seven in all – who suggested a variety of possible diagnoses and treatments. Depending

on the version, she was possessed by a snake, a mountain spirit, or a fox. The last interpretation seemed to Michiko to be the right one, to the extent that she identified the source of the voices as being the spirit of a fox killed by one of her ancestors. The special feature of this spirit was that it provided her with true information about the world and about her past. «I'm not cheating you, so listen carefully»; the fox told her before proceeding to recite her life story. The fox informed Michiko that she was of aristocratic origin, and that some of her ancestors were even connected to the imperial family. He also told her about matters that were not part of her personal history. For example, that the Chernobyl nuclear power disaster had been caused by a curse placed on the Soviet Union for shooting down a South Korean plane, and that Ronald Reagan had put a bomb on another plane, a Japanese plane, which caused a terrible accident. But the voices mainly spoke of unexplained incidents from Michiko's past: the fire that burned down her parents' house, the suspicion that their neighbour might have been involved, and the family's subsequent economic difficulties. According to Michiko:

> «The fox says that it will not go away until I prove the arson, because it has possessed me to let me know the truth. It is not an ordinary fox but a box fox. And the fox is a follower of the fox deity, so it should know everything.» (1991: 457)

Over the years, the voices did not disappear, but Michiko experienced a change of great significance. After several failed attempts, she became a shaman in a Buddhist sect (*shugendo*) in a desperate attempt to cure her. In her own words:

> «I finally had the first client. A brother or a sister of a friend of my colleague suddenly disappeared. The spirit behind me told me to search for him/her. So I guessed the place. I didn't receive any money because he or she is not yet found... I still work on religious practice every day. I'll keep on doing it because it has made me what I am.» (1991: 459)

Matsuoka's account of this case is important not only for its portrait of Michiko's experiential universe, but also for the way it is presented in an ethnographic context. Articles of this kind – like Newman's, which opened the previous section – are not unusual in anthropological literature. However, when Matsuoka's analysis is contrasted with Newman's, some interesting divergences in their ethnographic styles emerge. For instance, Michiko speaks extensively in the first person, whereas Gambiri tells us hardly anything in his own words. In fact, these two articles construct affliction in markedly different ways. Whereas Newman behaviouralizes Gambiri's discourse, Matsuoka discursivizes Michiko's behaviour. In Matsuoka's article, in fact, the patient's narrative is at the core of the eth-

nographic analysis. The central issue is not behaviour and sequences of behavioural response, but the significance of indigenous discourse, to such an extent that behaviour is accessible only through the informant's narrative. This not only affects the transcription of Michiko's narrative, but also the analytic concepts that the Japanese ethnographer uses to unravel the case and develop a coherent interpretation of it. Matsuoka does not speak in terms of patterns of misconduct, ethnic disorders, the ethnic unconscious, social deviance, or folk taxonomies, instead treating Michiko's illness as a metaphor with a number of possible interpretations: shamanic, psychiatric, and anthropological (which includes the sufferer's narrative).

This range of possible interpretations does not reproduce Newman's analytic strategy using different variables. Matsuoka's aim is not to construct a definitive explanation, but simply to juxtapose different readings of the same case. Of course, this juxtaposition is not gratuitous; she means to show us that one of these readings is more likely, a strategy to shed as much light as possible on the curious case of *Kitsune-Tsuki*. A causalist or etiological model, she observes, is much less productive than an interpretative approach, which gives the informant's symptoms their "metaphoric" and polysemic nature. In other words, she does not attempt to explain away possession as a pathoplastic form of a disease – which in this case could easily be schizophrenia – but ventures into the domain of meaning, placing the informant's illness narrative in relation to a larger frame of reference. And what she finds, first of all, is a plural universe of meanings, which Michiko uses alternately, and even simultaneously, reflecting a context in which different medical systems coexist. Second – and more importantly for my purposes – she also finds that fox possession is a reflexive symbol that provides Michiko with an opportunity to think about her genealogy and ancestors. This symbol – which is also a symptom – turns the fox into a liminal agent which voices the truth of a life, a local, cultural instrument for reflection.

Everything suggests that Michiko's symptoms are like representations, which cannot be understood outside the cultural context in which foxes and the memory of ancestors acquire meaning. But what is less clear, although also true, is that Matsuoka's text cannot be understood outside the universe of knowledge in which it has been produced. That is to say, in the framework of an interpretative medical and psychiatric anthropology which investigates the meaning of illness and symptoms through such concepts as symbol, metaphor, narrative, semantic networks, idioms of distress and so on (Kleinman 1980; 1988a; 1988b; Good 1977; Good and Good 1981; Nichter 1981). This approach, unlike Gambiri's ethnography, speaks not of behav-

iours, functions or patterns of misconduct that must be explained, but of meanings and expressions that must be decoded.

The turn toward an interpretative perception of symptoms is the result of a succession of influences such as hermeneutic philosophy, symbolic and interpretative anthropology, and interpretative medical anthropology. Particularly important in this last case is the work of scholars such as Kleinman, with his precocious ideas about the meaning of illness and suffering (1980), and Byron Good, with his concept of semantic illness networks. This concept formulated in the well-known article *The Heart of what's the Matter: The Semantic of Illness in Iran* (Good, 1977) considers illness and its expressions as a dominant symbol which condenses emotions and feelings, meanings and situations, afflictions and social rules. Applying it to interpret a complaint such as the "*narahatiye qalb*", present in the Turk-speaking people in the East Azerbaijan province in Northwest Iran precedes the interpretative elements present in Matsuoka's article: the hermeneutics of the emic dimension of illness by immersion in its symptoms and its narrative and text analysis, the use of linguistic and semiotic models, and the critics of biomedicine.

But the most evident appropriation and reformulation of the concept of symptom is, without doubt, a subsequent article by Byron and Mary-Jo DelVecchio Good entitled *The Meaning of symptoms*, in which the authors show how to deal with this new object: the symptom as a condenser of meanings. Whereas the biomedical model searches for somatic or psychophysiological lesions, the hermeneutic model investigates the constructions of meanings: «the illness reality of the sufferer» (1981: 179). Whereas the former proceeds clinically and with the support of organic evidence, the latter decodes the semantic networks. Whereas the biomedical model «dialectically explores relationships between symptoms and somatic disorder», the hermeneutic model interprets symptoms as texts in their relation with the semantic networks as a context. In short, while one operates in the explanation mode (*Erklärung*), the other opts for the understanding mode (*Verstehen*) (1981: 179). In this context the following statement makes sense:

> «Symptoms do not reflect somatic abnormalities in any simple way and the relationship among symptoms does not mirror a set of mechanistic or functional physiological relationships. Symptoms are irreducibly meaningful. Illness and symptoms are experienced as realities and are thus integrated, logically and meaningfully.» (Good and Good 1981:191)

Such an evident identification between symptom and meaning is only possible within an interpretative anthropology of illness. The notion of symptom is appropriated in both a critical and furtive manner since while Good

and Good point out the vacuums produced by an excessive biologization of medicine they also suggest new ethnographic territories. Thus, symptom is transformed into a relevant concept for anthropology. We are now immersed in the *episteme* within which symptom and meaning meet, in the same manner, perhaps, that according to Foucault the umbrella and the sewing machine are found together on the operating table. Now symptoms mean.

Notes

(1) «It was an extension of microscopic techniques for the study of cell preparations and the use of synthetic aniline stains (manufactured in Germany after 1870) that led, for the first time in the history of medicine, to a therapeutic technique that was both effective and unrelated to any medical theory: chemotherapy, invented by Paul Ehrlich (1854-1915)».

(2) Even "heart" can mean different things for physicians of different national traditions, as Thomas Ots has pointed out in his article *A heart is not a heart is not a heart is not a heart* (1993: 397).

(3) This is generally true for European psychoanalysis; for example, the Lacanian School, which is closer to the humanities than to biomedicine and biomedical psychiatry. This is evident from a glance at Lacan's *Écrits* (1966) and at his *Séminaire.*

(4) An 18th Century clinician who tried to cure a case of hysteria with ten to twelve hours of baths a day for ten months.

(5) The first 19th Century doctor who observed and described the encephalic lesions of general paralysis of the insane (GPI) or paresis (1972: V).

(6) For an in-depth review of this topic, see Martínez-Hernáez (2000).

(7) I am thinking of Borges' curious animal taxonomy that Foucault uses in the preface to *Les mots et les choses* and of the famous couple (introduced previously by Lautréamont) formed by the umbrella and the sewing machine on the operating table outlined in the same preface.

(8) The labels are *Clinically Applied Anthropology* (Chrisman and Johnson 1990), *Critical Medical Anthropology* (Baer, Singer and Johnsen 1986), *Critically Applied Medical Anthropology* (Scheper-Hughes 1990), *Critically Interpretive Medical Anthropology* (Lock and Scheper-Hughes 1990), *meaning-centered approach* (Good 1994), *embodiment paradigm* (Csordas 1994), etc.

(9) See Kleinman 1980:119; Good 1977: 27: Good and Good 1981: 165; Good 1994: 92; Scheper-Hughes 1992: 167; Lock 1990: 237.

(10) Here we have used Newman's work. However, any article of the period would have a similar approach. See particularly Harris (1957), Mischel & Mischel (1958), Langness (1965) and Parker (1960).

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