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AM *Rivista della Società italiana di antropologia medica*

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AM. Rivista della Società italiana di antropologia medica è una testata semestrale della Fondazione Angelo Celli per una cultura della salute (Perugia) e viene realizzata con la collaborazione della Sezione antropologica [già Istituto di etnologia e antropologia culturale] del Dipartimento Uomo & Territorio della Università degli studi di Perugia.

AM

RIVISTA DELLA SOCIETÀ ITALIANA DI ANTROPOLOGIA MEDICA

Themes in Medical Anthropology

Medical Anthropology at Home contributes to health studies

a cura di
JOSEP MARIA COMELLES - ELS VAN DONGEN

13-14
ottobre 2002

Fondazione Angelo Celli per una Cultura della Salute – Perugia

ARGO

Frontespizio del volume *Anatomica* di Jean Riolan il giovane (Paris, 1580 - Paris, 1657).

Frontispiece of the book *Anatomica* by Jean Riolan the younger (Paris, 1580 - Paris, 1657).

Il logo della Società italiana di antropologia medica, qui riprodotto, costituisce la elaborazione grafica di un ideogramma cinese molto antico che ha via via assunto il significato di "*longevità*", risultato di una vita consapevolmente condotta lungo una ininterrotta via di armonia e di equilibrio.

The logo of the Società italiana di antropologia medica here reprinted is the graphic elaboration of an ancient Chinese ideogram which progressively assumed the meaning of "*longevity*", the outcome of a life consciously lived following a never-ending path of harmony and balance.

AM
Rivista della Società italiana di antropologia medica

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n. 13-14, ottobre 2002

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Ai lettori

La Direzione e il Comitato di redazione di *AM* hanno accettato la proposta fatta dai Curatori degli atti della Seconda sessione di *Medical Anthropology at Home* di pubblicare su questa rivista il risultato del loro lavoro.

Medical Anthropology at Home è una rete, prevalentemente europea, di antropologi medici che svolgono larga parte delle loro ricerche nel proprio paese. Una attività di ricerca dunque, condotta nel medesimo contesto territoriale in cui il ricercatore vive la sua "normale" vicenda personale e professionale: una condizione, perciò, in cui sia il ricercatore sia coloro sui quali egli indaga sono radicati in un unico e medesimo contesto sociale, insieme ai problemi da cui la ricerca nasce, ai poteri che la promuovono, alle ricadute concrete che ne risultano, alle attese che essa suscita e a una conseguente responsabilizzazione del ricercatore, che giorno dopo giorno gioca nel suo stesso ambiente la propria credibilità. Una condizione ben diversa, occorre dirlo, dalle pratiche di ricerca *abroad*, lontane cioè dalla vita quotidiana del ricercatore, in cui il "suo ritorno a casa" rompe più o meno definitivamente ogni rapporto con coloro cui l'indagine è stata rivolta.

La rete *Medical Anthropology at Home* ha preso avvio a Zeist, in Olanda, nei giorni 16-18 aprile del 1998, in una prima sessione organizzata dalla Unità di antropologia medica della Universiteit van Amsterdam. In merito se ne può vedere un lungo resoconto di Ivo Quaranta su questa stessa rivista, alle pp. 300-308 del numero 5-6, ottobre 1998.

La Seconda sessione di *Medical Anthropology at Home* ha avuto luogo nei giorni 19-21 aprile del 2001 a Tarragona, in Catalogna, Spagna, organizzata dal Departament d'antropologia social i filosofia della Universitat Rovira i Virgili. In questa Seconda sessione, in riconoscimento del contributo che l'Italia ha dato sin dagli anni '50 ai moderni sviluppi della antropologia medica *at home*, la città di Perugia è stata indicata come sede per la Terza sessione della rete, nel 2003.

Peraltro, va sottolineato che a differenza di altri paesi occidentali nei quali le ricerche che oggi definiremmo di antropologia medica hanno avuto un esordio essenzialmente "coloniale", rivolto dunque a sistemi di cura esotici, in Italia gli studi di antropologia medica si sono sostanzialmente sviluppati sin dal secolo XIX e per tutto il '900 all'interno del paese: l'antropologia medica italiana, con la sua precoce articolata ed estesa tradizione di studi, è sempre stata, appunto, in larghissima misura una antropologia medica *at home*.

I Curatori degli atti della sessione di Tarragona, Josep María Comelles e Els van Dongen, hanno attentamente raccolto tutte le relazioni presentate in quella sessione, le hanno riorganizzate secondo una coerente articolazione tematica e ne hanno ricavato due ampi volumi, ciascuno dei quali munito di un titolo particolare che in qualche misura rappresenta una possibile sintesi dei temi che vi sono trattati: *Medical Anthropology and Anthropology. Contributions of Medical Anthropology to the theory of Health Studies* e *Themes in Medical Anthropology. Medical Anthropology at Home contributes to Health Studies*. I contributi vengono tutti presentati in inglese, la lingua ufficiale in cui si sono svolti i lavori a Tarragona, e i relativi testi sono stati sottoposti, prima della loro pubblicazione, a una revisione condotta sotto la responsabilità dei Curatori da una équipe di esperti di madrelingua. Non è di scarso significato per gli sviluppi della rete, tuttavia, che proprio a Tarragona, su proposta della delegazione italiana – a garanzia di un maggiore equilibrio fra le grandi aree linguistico-culturali europee e al fine di evidenziare la ricchezza e le numerose specificità di quella che potremmo definire una antropologia medica “latina”, dall’Italia alla Spagna, dal Messico al Brasile – la rete ha riconosciuto da allora in avanti come propria lingua ufficiale, accanto all’inglese anche lo spagnolo. E così sarà già dalla sessione di Perugia.

Il vastissimo materiale costituito dai due volumi messi a punto dai Curatori ha reso necessario che anche *AM* dedicasse due dei propri volumi alla pubblicazione degli esiti della sessione di Tarragona: così i volumi di *AM* 11-12 (2001) e 13-14 (2002) escono assieme e verranno presentati a Perugia nel corso della Terza sessione della rete.

Dobbiamo agli abituali lettori di *AM* almeno due altre precisazioni. Conformemente alla prassi della rivista, tutti i contributi dovrebbero recare il relativo riassunto (italiano, francese, spagnolo, inglese) e una scheda sull’Autore. Per ragioni tecniche del lavoro di curatela, ciò è risultato impossibile e ci si è dovuti limitare alle qualifiche degli Autori indicate accanto al loro nome sotto il titolo dei contributi. Parimenti, le convenzioni per i riferimenti bibliografici, definite “ab origine” dagli Organizzatori della Seconda sessione e ribadite poi dai Curatori del volume non prevedono alcuni dati da noi normalmente richiesti e non corrispondono comunque esattamente a quelle adottate dalla nostra rivista. Ma ovviamente, sarebbe stato pressochè impossibile e illegittimo, dopo la decisione di pubblicare gli atti su *AM*, richiedere a posteriori agli Autori il riesame dei loro contributi per un adeguamento a convenzioni inizialmente non prescritte.

Questa pubblicazione è stata resa possibile dai contributi finanziari della Universiteit van Amsterdam, della Universitat Rovira i Virgili (Tarragona), della Fondazione Angelo Celli per una Cultura della Salute (Perugia) e della Società Italiana di Antropologia Medica. A queste istituzioni, oltreché naturalmente ai Curatori e a tutti gli Autori che hanno partecipato a questa impresa, va il nostro ringraziamento.

Tullio Seppilli, direttore di *AM*

A los lectores

La Dirección y el Comité de redacción de *AM* han aceptado la propuesta de los Compiladores de las actas de la Segunda sesión de *Medical Anthropology at Home* de publicar en esta revista el resultado de su trabajo.

Medical Anthropology at Home es una red, por lo general europea, de antropólogos médicos que desarrollan gran parte de sus investigaciones en su propio país. Una actividad de investigación conducida en el mismo contexto territorial en el cual el investigador vive su "normal" situación personal y profesional. Sea el investigador que quienes son objeto de su investigación se encuentran en un mismo y único contexto social, junto a los problemas de los cuales la investigación nace, a los poderes que la promueven, a las recaídas que de estos resultan, a las expectativas que suscita y a una consecuente responsabilización del investigador, que se juega día tras día su propia credibilidad dentro su mismo ambiente. Una condición bien diferente a las prácticas de investigación *abroad*, o sea lejos de la vida cotidiana del investigador y que, además, rompe en su "regreso a casa" más o menos definitivamente toda relación con quienes fue hecha dicha investigación.

La red *Medical Anthropology at Home* empezó en Zeist (Holanda) los días 16-18 de abril 1998, en una Primera sesión organizada por la Unidad de antropología médica de la Universiteit van Amsterdam. Se puede leer una larga revisión del encuentro por parte de Ivo Quaranta en esta misma revista, pp. 300-308 del numero 5-6, octubre 1998.

La Segunda sesión de *Medical Anthropology at Home* se llevó a cabo del 19 al 21 de abril 2001 en Tarragona, Cataluña (España), esta vez organizada por el Departament d'antropologia social i filosofia de la Universitat Rovira i Virgili. Durante esta Segunda sesión, en reconocimiento a la contribución que Italia ha dado desde los años '50 al desarrollo de la antropología médica *at home*, la ciudad de Perugia fue indicada como sede para la Tercera sesión de la red.

Hay que subrayar, por otra parte, que a diferencia de otros países occidentales en los cuales las investigaciones que hoy definiremos de antropología médica tuvieron un exordio esencialmente "colonial", dirigido a sistemas de cura exóticos, en Italia los estudios de antropología médica se desarrollaron sustancialmente desde el siglo XIX y durante todo el siglo XX al interno del país: la antropología médica italiana, con su articulada y extensa precoz tradición de estudios fue siempre en amplia medida una antropología médica *at home*.

Los Compiladores de las actas de la sesión de Tarragona, Josep María Comelles y Els van Dongen, reunieron atentamente todas las ponencias presentadas en dicha sesión, las reorganizaron según una coherente articulación temática y obtuvieron dos amplios volúmenes, cada uno con un título particular que, hasta cierto punto, representa una posible síntesis de los temas que fueron tratados: *Medical Anthropology and Anthropology. Contributions of Medical Anthropology to the theory of Health Studies* e *Themes in Medical Anthropology. Medical Anthropology at Home contributes to Health Studies*. Las ponencias son presentadas en inglés, el idioma oficial de la sesión de Tarragona, y sus relativos textos estuvieron sujetos, antes de su publicación, a una revisión por parte de un equipo de expertos de lengua materna bajo la responsabilidad de los Compiladores de las actas. No es de poca importancia para el desarrollo de la red que a Tarragona, bajo propuesta de la delegación italiana – para garantizar un mayor equilibrio entre las grandes áreas lingüístico-culturales europeas y para evidenciar la riqueza y los numerosos distintivos de una antropología médica "latina": de Italia a España, de México a Brasil – la red reconoció al español, desde ese entonces, como idioma oficial junto al inglés. Y así será en la sesión de Perugia.

El vastísimo material incluido en los dos volúmenes antes mencionados ha hecho necesario que *AM* también dedicase dos volúmenes a la publicación de los resultados de la sesión de Tarragona: así, los volúmenes de *AM* 11-12 (2001) y 13-14 (2002) son publicados al mismo tiempo y se presentarán en Perugia durante la Tercera sesión de la red.

Debemos a los lectores habituales de *AM* al menos otras dos precisiones. Conforme a la praxis de la revista, todas los textos deberían tener su relativo resumen (en italiano, francés, español, inglés) y una ficha sobre el Autor. Por razones técnicas del trabajo de compilación nos fue imposible inserirlos en la publicación y nos tuvimos que limitar a indicar las calificaciones de los Autores indicadas junto al nombre, abajo del título del texto. En cuanto a las referencias bibliográficas, definidas "ab origine" por los Organizadores de la Segunda sesión y reafirmadas por los Compiladores de las actas del volumen, no prevén algunos datos que normalmente solicitamos y no corresponden exactamente a las normas utilizadas por nuestra revista. Obviamente hubiera sido imposible e ilegítimo, después de la decisión de publicar las actas en *AM*, pedir "a posteriori" a los Autores la reexaminación de sus textos para una adaptación a convenciones inicialmente no prescritas.

Esta publicación fue posible gracias a la contribución de la Universiteit van Amsterdam, de la Universitat Rovira i Virgili (Tarragona), de la Fondazione Angelo Celli per una Cultura della Salute (Perugia) y de la Società Italiana di Antropologia Medica. Agradecemos a estos institutos, a los Compiladores y a todos los Autores que han participado a esta empresa.

Tullio Seppilli, director de *AM*

[traducido del italiano por Corinne Meléndez]

To our readers

The Editor and Editorial Committee of *AM* are happy to accept the proposal of the Editors of the proceedings of the Second Session of *Medical Anthropology at Home* to publish the proceedings in our review.

Medical Anthropology at Home is a mainly European network of medical anthropologists who carry out a great part of their research in their own country. This is, then, research that is carried out in the same territorial context as the researcher lives his/her own normal personal and professional life. It is thus a condition in which both the researcher and those being researched find themselves within one and the same social context, together with the problems that give birth to the research, with the powers that promote the research, with the concrete spin-offs that result from it, with the expectations that it gives rise to and with the consequent taking on of responsibility by the researcher who, in this self-same environment, has day-by-day to put his/her credibility on the line. One must therefore say that this is a very different condition from research practice *abroad*, in other words far from the daily life of the researcher, for whom the "return home" represents a more or less final break in relationships with those who were object of the study.

The *Medical Anthropology at Home* network began life in Zeist (Holland) on 16-18 April 1998 at the first conference organized by the Medical Anthropology Unit of the Universiteit van Amsterdam, on the subject of which readers of *AM* may find an summary article by Ivo Quaranta on pp. 300-308 of the double number 5-6 (October 1998).

The second conference of *Medical Anthropology at Home* took place on 19-21 April 2001 at Tarragona in Catalonia (Spain) and was organized by the Department of Social Anthropology and Philosophy of the Universitat Rovira i Virgili (Tarragona). In recognition of the contribution to medical anthropology at home that Italy has made since the 1950s, the second conference chose Perugia as the city for the network's third (2003) conference.

It must moreover be emphasized that, different from other Western countries in which research that we should now define as medical anthropology had an essentially "colonial" beginning, and was therefore focused on exotic medical systems, medical anthropology studies in Italy in substance developed in the nineteenth and throughout the whole of the twentieth century within the country. Italian medical anthropology, with its early articulated and extended tradition of study has always, then, been to a very large extent a medical anthropology “at home”.

Josep María Comelles and Els van Dongen, the Editors of the proceedings of the Tarragona conference, have with great care collected together all the contributions there presented, reorganizing them thematically and have thus produced two substantial volumes, each of which bears its own specific title reflecting the contents in summary form. The two volumes are: *Medical Anthropology and Anthropology. Contributions of Medical Anthropology to the Theory of Health Studies* and *Themes in Medical Anthropology. Medical Anthropology at Home Contributes to Health Studies*. The contributions are all in English, the official language of the Tarragona conference, and the corresponding texts have all been revised by a team of mother-tongue experts working under the direction of the Editors of the conference proceedings. It is of no little significance for the development of the network, however, that at Tarragona an Italian proposal was accepted to adopt Spanish as an official language alongside English. This guarantees a better equilibrium among the great cultural-linguistic areas of Europe with the aim of also bringing out the richness and numerous specificities of what might be termed a “Latin” medical anthropology, going from Italy to Spain, Mexico and Brazil. This will take effect as from the conference in Perugia.

The vast material that constitutes the two volumes produced by the conference Editors has made it necessary for *AM* to devote two of its double numbers to publishing the proceedings of the Tarragona conference and thus numbers 11-12 (2001) and 13-14 (2002) of *AM* will come out simultaneously and be presented at Perugia during the third conference of the network.

At least two guidelines must be made clear to readers of *AM*. As is established practice with *AM* all contributions must provide an abstract in Italian, French, Spanish and English, together with note about the Author. For technical reasons this was impossible for the Editors of the Tarragona proceedings who had to be content with more generic information regarding the professional status of the Authors, included under the title of their contribution. Likewise, the bibliographical conventions, defined “on the spot” by the Organizers of the Tarragona conference and confirmed by the conference proceeding Editors, do not include certain data that we normally require and in any case do not conform exactly to those adopted by our review. After the decision to publish the conference proceedings in *AM* it would obviously however have been almost impossible, as well as not being legitimate, to have asked Authors to revise their contributions to bring them into line with conventions that had initially not been laid down.

The current publication has been made possible thanks to the financial contributions of the Universiteit van Amsterdam, of the Universitat Rovira i Virgili (Tarragona), of the Fondazione Angelo Celli per una Cultura della Salute (Perugia) and of the Società Italiana di Antropologia Medica. To these institutions, as well of course as to the Editors and all the Authors who have taken part in this undertaking, go our heartfelt thanks.

Tullio Seppilli, editor of *AM*
[translated from Italian by Derek Boothman]

Presentation

Els van Dongen and Josep Maria Comelles

This is the preface to a collection of ethnographic papers. The volume grew out of the Second Meeting of Medical Anthropology at Home in 2001 in Tarragona, Spain. When the meeting ended, we decided to revise and rewrite our contributions. The lively discussions during the meeting provided all of us with enough comments and new inspiration to do so.

Those who are inclined to the challenge of medical anthropology at home will get a good idea about the work of anthropologists who have studied their own societies for many years. The volume has four main themes – the influence of medical Anthropology within anthropology, the Body, migrations, and commitment, ethics and applied anthropology and within those broad themes the reader will find a wide variety of sub themes. The studies cover a wide geographical area; from the North of Europe to the South and from the West to the East.

The papers generate rich and detailed data about health and illness in a European context. They attempt to show the relevance of medical anthropology in Medicine and Anthropology today, particularly in the context of the welfare state. The papers also show the 'differences within' European diversity and discuss the problems of conceptualisation and comparison.

We are grateful for the many contributions to the conference and – subsequently – to this volume, the first to come out of the meeting. We would also like to thank our Italian colleagues Tullio Seppilli and Pino Schirripa who offered a 'home' for our papers and made this publication possible. We thank the University of Amsterdam, the Medical Anthropology Unit, the University Rovira i Virgili, the Fondazione Angelo Celli in Perugia and the Società italiana di antropologia medica for providing technical and financial support.

NARRATIVES

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Introduction

Els van Dongen

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Illness experiences have become an area of interest in the social sciences. Medical anthropology focuses on ‘the lived experience’ of what is going on in bodies and lives. Anthropological studies of illness narratives see illnesses as polysemic and multivocal. Meanings of illness are personal, social and cultural. They reveal what it means to be ill. Anthropologists have argued that narratives are the forms ‘in which experience is represented and recounted’. The first section Narratives – shows that narratives serve a variety of ends in people’s lives.

Vibeke Steffen describes how narratives are an expression of people’s perspectives and experiences with alcoholism, but are also used for structuring therapy. She shows the role of nature and nurture in narratives of addiction. These narratives are related to master-narratives of social heritage. Steffen makes the point that her informants reacted ironically when she made an appointment to talk with them more in-depth. Remarks such as “Remember to bring your family pictures” or “prepare your childhood story” shows the status of narratives in people’s minds. Indeed, anthropologists should not only use narratives and stories; hanging around, observing, being there is essential too.

Rinken focuses on the Western form of subjectivity and identity by linking HIV, mortality and the self. In his paper, narratives serve as a means for self-construction. This needs self-reflection (self-narration) in order to establish change and transformation in one’s life.

Jennifer Parr analyses the active role of the anthropologist as a facilitator in a pilot health setting in Cape Town. Parr confronts us with the anthropologist’s narrative. Often, this reflexive narrative is difficult to tell in the setting where the anthropologist has to work.

Narratives of women about the risk of osteoporosis are full of metaphors. Susan Reventlow shows the changes in these stories after women had a bone-scan. Medical knowledge becomes embodied.

Against the background of ongoing change in the South African Health Care System, Diana Gibson shows the need for order, cohesion and pattern in health information systems. Gibson describes the development of an information culture and people's involvement. Ritualisation and brokering – anthropological concepts – are very useful in this process.

The final paper of this section focuses on food advertising. Mabel Gracia has studied how people experience and judge this advertising. Gracia concludes that advertising only has an effect within an ideological discourse of needs. Often, advertising starts with people's needs. It is presented as a solution to these needs.

The papers in this section strongly stress the importance of subjective accounts of people and an "emic" view. They show how people deal with their past; how they give meaning to the present and how they use their experiences for the future. Narratives – spoken words, written words and images – are at the heart of this enterprise. The papers show that the personal narratives are related to, and get their meaning from, the cultural context.

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Nature or nurture: narratives of descent and heritage in Danish cases of alcoholism

Vibeke Steffen

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Numerous studies in medical anthropology have stated that story telling plays a central role in illness and healing. Far from being restricted to traditional talk-therapies, narratives have been identified as important ways of expressing lay discourses on illness and as structuring principles for therapeutic action. It seems that the very nature of illness with its character of process and transformation, its dramatically posed questions of life and death, and its quest for action, is particularly apt for story making. While interest in life stories and illness narratives in anthropology has increased over the past decades, the popularity of talk therapies seems to be declining in areas of treatment for mental, emotional and social problems. This is also the case with treatment for alcoholism in Denmark, where new interest in cognitive-behavioural therapies is gaining territory from the psychodynamic approaches. These new approaches are sometimes referred to as "behavioural medicine" and consist of a mixture of cognitive-behavioural therapy, behaviour-adjusting therapy (for example neuro-linguistic programming), and pharmaceuticals – primarily the new anti-depressive medicines (DCAA 2001:8). Cognitive therapies are considered more effective, less time-consuming and easier to evaluate than psycho-dynamic therapies, and advocates of the cognitive approaches argue that it is unnecessary and indeed useless to search for explanations in childhood experiences and family relations in order to handle present problems.

Though many patients seem to welcome this change in practice, stories of family relations, descent and heritage, childhood and adolescence still play a central role in popular accounts of drinking problems. Not unlike what happened to the concept of culture in anthropology, popular ideas of psychology have become part of common lay knowledge to such an extent that professional scepticism and critique is not sufficient to change practice. While the new therapies attempt to rationalise treatment by ways of logical scientific thinking, patients often seem to cling to less rational narrative genres, perhaps rooted in the human genome or given in the nature of language, as Bruner suggested (1996:39).

The point was made clear to me last summer, when I conducted some fieldwork in an outpatient clinic for people with drinking problems run by the Link in Copenhagen. The clinic offers consultations with a doctor and a social caseworker, social activities, and various kinds of group therapies – among them structured relapse prevention. Most people, however, just go there to take their Antabus® medication and chat with the other clients. Accordingly, I also spent much of my time sitting in the ward's living room, listening and taking part in these ongoing conversations. Occasionally, I would ask someone for a personal interview, a request that often triggered jokes, comments and speculations about the contents of an interview with the anthropologist. Hints like "remember to bring your family pictures" or "prepare your childhood story" showed not only what people in general expected, but also the ambivalence and irony felt about the status of such information. Although the interviews were supposed to focus on experiences with Antabus® treatment, and though I stressed that I was neither a psychologist nor therapist, most participants in the study would begin the interview with accounts of where they grew up and the character of their family relations. When asked directly, whether they thought that was important for understanding their present problems, very few claimed that they did.

In general, personal stories contain theories of events and shared world-views as well as individual expressions of self and identity. This is partly due to the form or genre a story is fitted into, and partly due to the semantic content of culturally shared world-views. Though one might think that individual world-views would gain prominence in the course of therapeutic dialogue, more often therapeutic interactions seem to reinforce an official story version, as demonstrated by Capps and Ochs in their book on agoraphobia (1995). Thus, individual stories of illness or social crisis are often constructed in relation to master-narratives with a ritualised story-plot, working as a narrative interface between individual and society. This is clearly the case with personal life stories told by recovering alcoholics in groups of Alcoholics Anonymous (AA), usually referring to a shared theory of alcoholism as a disease (Steffen 1997). Stories among problem drinkers undergoing standard Antabus® treatment in the Danish public health care system usually adhere to a psycho-social theory of alcoholism, although they are less determinate in their explanatory references, and they tend to stress problems of social heritage. Both kinds of stories, however, reveal underlying storylines about descent and heritage nature or nurture. While biological heritage is often dealt with as something tangible and thus manageable, social heritage tends to be much more subtle and sticky: you may be able to cope with biology, but you cannot escape your social roots. With the new growing interest in genetics and recent developments in medical technologies, it is surprising that the awareness of social roots plays such an important part in Danish understandings of drinking problems.

The adherence to theories of social heritage revealed in stories of addiction has serious consequences for motivation and prospects of treatment. In spite of their reference to theories of biological heritage, the well-structured personal narratives often told at AA meetings serve well as therapeutic tools; the disorderly stories of repetitiousness and the quagmire philosophy of social heritage, however, cause problems for therapeutic interventions. At first sight, behavioural medicine might provide a good alternative to talking about the past, but since patients insist on the cultural themes of heritage and descent, questions of nature and nurture seem unavoidable.

This article builds on research of reform movements, medicines and spontaneous remission in recovery from alcoholism, carried out in Denmark over the past ten years (1). It discusses the role of nature and nurture in narratives of addiction, as told by people with serious drinking problems, and the implications of such narratives for therapeutic action. I wish to suggest that narratives have multiple layers, that different layers may serve different ends, and that although individuals and social institutions may adhere to changing explanatory models and ideologies of nature or nurture, they all seem to submit to a culturally shared master-narrative of heritage and descent. First, some information about the treatment of alcoholism in Denmark may be useful.

Medicine and the spirit of control

Treatment of alcoholism in Denmark is totally dominated by Antabus® medication and has been for over half a century (Thorsen 1993). Antabus® is a medicine that interferes with the breakdown of alcohol in the body by producing very unpleasant toxic symptoms almost immediately after intake. The drug does not treat alcoholism as such, but is taken as a preventive medicine in order to support the patient's will to stop drinking by providing an automatic physical punishment (2). Antabus® is routinely offered to anyone who contacts the Danish public health care system about problems with alcohol, whether this contact goes through general practitioners, outpatient clinics, hospital wards or asylums. Research from 1988 showed that Antabus® was used in more than 90 per cent of all cases in the public outpatient wards (Skinhøj 1988:23).

The effect of Antabus® is normally maintained by an intake twice a week, for which the patient is requested to show up at an outpatient clinic or at the general practitioner's to take the drug under strict control in order to prevent cheating (Steffen 2001). The idea is, of course, that the fear of unpleasant reactions should prevent the person from drinking. According to this logic, will power to resist drinking only has to be mobilised twice a week instead of every time the temptation of a drink comes up, and to some patients Antabus® does seem to have that effect. Some actually manage to stay sober on Antabus® for many years, but more commonly, this medication falls into a periodic pattern of three to six months of abstinence followed by rather dramatic binges.

One of the many institutions offering this treatment in Denmark is the Link. The Link is a co-operation between the National Association of the Link, a fellowship of people with alcohol problems and nearest relations, and the Link Outpatient Clinics in Denmark, a private foundation (though publicly funded) offering professional treatment for alcohol abuse. The aim of the Link fellowship is to help anyone who wishes to gain control over his or her alcohol consumption. The Danish branch of the Link was founded in 1954 and was originally inspired by the AA concept of mutual self-help. However, the Link rejects the spiritual character of the AA programme and the principle of anonymity as a condition for their work. The history of the two organisations has led them in very different directions, but perhaps the most significant difference lies in their basic understanding of alcohol problems. While AA uses the concept 'alcoholic', indicating a special internal characteristic of the person (nature), the Link insists on talking about 'people with alcohol problems', suggesting a multi-factorial external approach (nurture).

The most prominent alternative to Antabus® treatment is the mutual aid fellowship of Alcoholics Anonymous (AA) and the related Minnesota Model; an institutionalised private treatment programme based on AA's 12 steps for recovery. In contrast to other Nordic and European countries, the first stable AA groups in Denmark did not appear until the late 1970s, but with the introduction of the Minnesota Model treatment in 1985, the fellowship has spread to all corners of the country. The Minnesota Model was initially received with some reluctance, and referred to a place on the margins of the public health care system as a private alternative therapy without the blue stamp of official authorisation required for systematic public funding. The basic arguments against authorisation were that the programme was based on a disease model of alcoholism and that it was considered religious (Steffen 1993). Over the years, though, acceptance has increased and the Minnesota Model treatment is slowly getting a proper share of the public funding for treatment programmes.

The mixture of medical treatment, psycho-social interventions and 12-step programmes has resulted in very arbitrary definitions and ideas of alcoholism in Denmark ranging from the claim that there is no such thing as alcoholism at all – only different drinking habits – to very rigid ideas of physical disease. Although few (particularly professionals) explicitly submit to a disease model of alcoholism, many do seem to embrace the idea, that alcoholism is primarily a problem of self-control – or more precisely loss of control (in fact, one of the basic premises of the classic disease model). An act passed in 1958 states that alcoholism is a disease and should be treated as such; therefore; the public health care system is responsible for providing proper treatment. In practice, however, most treatment is carried out by publicly funded private organisations, some based on Christian charity, or institutions belonging to the system of social care, in accordance with the idea that alcoholism is a consequence of psychological problems and poor social conditions.

The multiplicity and the arbitrariness of ideas reflected in the stories told by people with drinking problems as well as professionals often results in very vague ideas of treatment goals and a rather pessimistic view on prognosis. It is worth noting, however, that different views – although arbitrary – are not necessarily mutually exclusive. As Fainzang shows in a French study of discourses on causality in alcoholism, ideas about symptoms and causes are often mixed, allowing a multiplicity of explanatory models to exist side by side (Fainzang 1994:89, 92).

Narrative and the ethos of success

The creation of order and meaning through story telling is often stressed in narrative analysis, especially regarding illness narratives. Narratives are stories that create order from troubling events through structuring principles such as temporality and plot. We draw on the past to cope with the present and use our experiences to grapple with the future. The meaning-centred narrative approaches in medical anthropology have been very prominent in clinical work, and Cheryl Mattingly, in particular, has brought new life to this trend with her study of occupational therapy (1994, 1998). Stressing the narrative construction of lived time in social interaction, Mattingly demonstrates the importance of intentionality, motive and action as key structuring devices in therapy. We act because we intend to get something done, to begin something, which we hope will lead us along a desirable route, and we try to make actions cumulative with a sense of an ending (Mattingly 1994:813). Though this story-plot by definition must be the essence of any rehabilitation effort to make it meaningful, Mattingly shows that therapists often need to transform "passive patients" into "active patients" if they are to be persuaded to work towards this goal. Motivational desires and intentionality are defined and given expression just as much by professionals and the institutional setting they are part of as by the patients being rehabilitated. Hence, the construction of narrative action is mainly the result of the therapists' goal-oriented efforts to steer towards desirable endings, rather than an inherent characteristic of narrative.

Because the clinical narratives in this case are embedded in an institutional rehabilitation programme, the prototype narrative steered at is the successful one. Even when the goals may seem humble and the results are meagre; the preferred narrative is of course the one that leads towards a happy conclusion. Suspense and uncertainty characterise the good story, but in the therapeutic plot, the indications of an uncertain future are minimised to the extent that the story itself depends on it. Since there is no story where there is no desire, much of the initial work of the therapist is to make therapy a place where there is something to care about (Mattingly 1994:818). Mattingly also states that the study of a clinical encounter as an unfolding story easily leads to the recognition of its ethical content, a quest for the moral of the story. The moral negotiation may be hidden in the clinical world, perhaps not so much because of the technicalities of medical procedures, as Mattingly suggests, but rather because of the neglect of the world outside the institution and what might be called the ethos of that society. The stories not only rely on the institutional setting of therapy and rehabilitation, but also on a general cultural spirit of action and being the master of your own life, and a moral viewpoint that problems should be viewed as challenges rather than restrictions.

This ethos may also have set its marks on anthropological thinking. The meaning-centred approach in medical anthropology is grounded in the assumption that entities are given meaning through being experienced, and in the notion that narrative is an essential resource in the struggle to bring experiences to conscious awareness. Through narrative, a reflective awareness of being-in-the-world is unfolded, including a sense of one's past and future. We come to know ourselves as we use narrative to apprehend experiences and navigate relationships with others (Ochs and Capps 1996:21). In our anthropological analyses, we tend to think of experience itself as a reflexive process that rests on a person's cognitive abilities to reflect on and make introspective sense of his or her engagement in the world (Desjarlais 1997:14). However, while we take this notion of experience for granted, we also tend to overlook that experience in this specific sense is the result of specific cultural articulations of selfhood. In his study of the homeless residents of a shelter in Boston, Robert Desjarlais states, that many of these residents did not live by way of a narrative process that proceeded, cohered, and transformed through temporally integrative forms. Rather, they were just "struggling along" as one of the residents put it. Their reality of homelessness entailed the absence of narratives – a homeless life with no story line (Desjarlais 1997:23).

I recognise this point from my own fieldwork among people with drinking problems in Denmark, where stories of success are rare and genuine optimism hard to find. Personal narratives are not absent, but meaning, coherence and intentionality are not always the most prominent traits. Instead, a sense of being stuck in the mud of inexpedient behavioural patterns carried on through generations seems to prevail. Descent and heritage may be thought of interchangeably as nature or nurture, but they always play a role. This does not mean that people do not have hopes for the future or that they do not adhere to theories and explanatory models, but the stories have many layers that play on different themes and serve different ends. To show the multiplicity of self-understandings and the cultural themes present in these narratives, and the difficulties of finding coherence and meaning in personal experiences, I have found Ochs and Capps' suggestions of narrative multiplicity useful (Ochs and Capps 1995, 1996). As they state, narrative activity places narrators and listeners in the paradoxical position of creating coherence out of lived experience, while at the same time reckoning with its impossibility. This struggle to reconcile expectation with experience may be particularly salient in the narratives of sufferers of alcoholism and other mental, emotional and social problems. I shall try to demonstrate this through three kinds of stories not mutually exclusive, but referring to different layers of meaning and thus leading to different ways of grappling with reality.

Conjuration

That narrative not only brings order and meaning to lived experience, but also brings multiple, partial selves to life, and urges tellers to grapple with the inconsistencies of reality, is evident even when looking at the most well-orchestrated stories. Regardless of their elaborateness, accounts of personal experience are always fragmented intimations of experience. With their potential of relating to a multiplicity of cultural themes, stories do not always provide the expected soothing coherence and order or solutions to life's dilemmas for the narrator, but may just as well raise new challenging questions. Faced with such frustration, the narrator may alternate between two main tendencies: either a relativistic perspective by cultivating a dialogue between diverse understandings and a fundamentalist perspective by laying down one coherent solution to the problem. While the relativistic tendency offers a potentially infinite range of interpretative frames for organising experience and promotes openness to new ideas, it can also lead to a paralysing sense of indeterminacy. The fundamentalist tendency, on the other hand, lends consistency to otherwise fragmented experiences and allows the narrator to assess what is happening in an expedient manner (Ochs and Capps 1996:32). In situations of personal crisis, when people tend to assent to notions of absolute authority and objective knowledge, fundamentalist ideas may often prevail. On these occasions, such beliefs may be both instrumentally necessary and existentially true, because they help the individual to regain a sense of control over his or her life (Jackson 1996:13).

The AA programme is often interpreted in such fundamentalist ways. The programme suggests that the only realistic solution to problems of addiction is total and lifelong abstinence, and that striving after a sober life goes hand in hand with striving after personal and spiritual development. An important activity in AA recovery work is, in fact, story telling. Sharing experiences through story telling is both a way of recruiting new members and a technique for mutual aid. The prototype AA story is temporally structured and retrospectively told, the protagonist looking back at his or her life, interpreting former events from the present position of recovery in AA, and casting hopes and desires into an imagined future. The stories often build up towards a transformative climax, revealing a dramatic plot of life and death and a moral about the nature of alcoholism. Eventually, other members comment upon the stories. They will compare and add their own experiences to those of the narrator and thus gradually change the story into an inter-subjective product, a prototype narrative very close in content to the AA myth of origin, the story of the founders (Steffen

1997). The retrospective position from which stories are told in AA clearly shows how experience is structured as narrative, how it works as an intersubjective learning process (Lave and Wenger 1991), and how it strengthens feelings of mutual identity (Cain 1991). Thus, accepting and settling for a specific version of reality, into which your own personal story can be integrated, is a useful therapeutic tool for many people. Hans, a fifty-year-old man who attended Minnesota Model treatment almost ten years ago, stated the following:

> *«I won't start analysing why the programme works or why I am an alcoholic – that's just the way it is. If I start analysing, I may find an answer to the why, and if I know why, I may very well persuade myself, that I can solve the problem, and then all of a sudden I think that I'm in control. I've tried that so many times, and it doesn't work that way. Suddenly, you're into all kinds of intricate explanations and ways of identifying risk-situations, and how to avoid them. It just doesn't work with that kind of speculations – I've simply accepted; that I'm an alcoholic, and I've made it a lifestyle. It puts an end to the explanations. As they say: "AA is a simple programme for complicated people!»*

A popular AA slogan summons members to "keep it simple", but that is obviously easier said than done. Through regular meetings, the members keep the programme alive but, even so, personal experiences and alternative interpretations constantly challenge basic notions. The fundamentalist perspective deliberately chosen by Hans seems to work as a conjuration or an invocation to prevent him from further atrocities rather than as a meaningful explanation. Like the presentation: "I am an alcoholic", systematically used at AA meetings, it works as a magic device to free the individual from further speculation. In that sense, the AA narrative may be seen as a statement about a certain condition more than an intellectually and existentially satisfying means of self-understanding. It is also a story that takes some effort for most Danes to stick to. Nevertheless, the story does provide structure and coherence to past experiences, and provides guidelines for the future together with the AA programme. Nevertheless, for most people some questions remain unanswered and other story lines pop up with supplementary or sometimes even contradictory explanatory models, as when later in the conversation Hans ponders:

> *«I was 41, when I got into treatment, and I had been drinking for 17 years at that time. I think I was born an alcoholic, and perhaps my father was an alcoholic, too, but my mother governed him with an iron hand. Had she not totally controlled him, it might have been more obvious. However, she steered all of us. [...] I guess you always seek the well known, and it is very likely, that I sought that kind of steering in my marriage, too. Anyway, you may say that it took me a long time to grow up and that it has had enormous consequences – also for my children. They drag the behavioural heritage with them, of course.»*

While Hans obviously accepts the disease model, strongly advocated by Minnesota Model treatment and by most AA groups in Denmark, he also adheres to an explanatory model based on social heritage. The story of "the strong (dominating) mother and the weak (alcoholic) father" is a very common one among people with alcohol problems along with other stories based on family conflicts and ideas of social heritage. It is characteristic for such stories that family patterns are considered very hard to break, and that they are likely to be carried on over generations: nature can be coped with, but nurture is inescapable. Thus, the idea of persistence in matters of social heritage creates very negative expectations for the prospect of change.

The importance of family relations is, of course, acknowledged in treatment and sometimes addressed through theories about "dysfunctional families" – a term even more popular in the treatment of relatives of alcoholics, so-called co-dependents. While AA groups tend to be anti-analytic and generally against psychological explanations, the Minnesota Model treatment uses these theories widely in practice. The professionalisation and institutionalisation of the twelve-step programme is an area of traditional conflict between AA and Minnesota Model treatment. AA members are often annoyed by the tendency to intellectualise and psychologise the programme; that takes place in professional treatment and thus influences the work of the groups (Steffen 1993). While people who are familiar with professional treatment will often stress their background in dysfunctional families, traditional AA stories as presented in the *Big Book* usually stress the fact that most alcoholics grow up in absolutely sound and ordinary families, and that the only reasonable explanation for their drinking problem is the disease model (AA 1960).

Confession

Adherence to a dominant narrative is community building in that it presumes that each member ascribes to a common story, and AA provides such a community into which a personal story can be told (Cain 1991, Steffen 1997). Narrators shape their accounts to accommodate circumstances such as the setting, and filter their personal experiences through choice of perspective. New identities are developed through stories told with others, which result in a complex, fluid matrix of co-authored selves. The co-narrators attempt to establish inter-subjectivity or empathy with one another in their tales but can of course only partially achieve this goal.

Thus, when a multiplicity of narratives are mapped onto a single telling, some persons may feel that they do not fit in, or may be disappointed upon realising that their narrative has not been heard or received in the intended spirit (Ochs & Capps 1996:32).

Reliance solely on a single dominant narrative often leads to oversimplification and discrepancies between the story that has been inculcated and one's encounters in the world. Within this narrative framework, individuals struggle to cultivate both diversity and coherence among potential and actual selves. Evidently, not all people feel comfortable with the AA ideology or find it easy to identify with its story-telling frames. It is well known that the programme does not work for everybody, and though the exact range of retention is hard to measure, surveys conducted in American groups throughout the past decades show that as many as 95% of newcomers drop out over a period of 12 months (McIntire 2000). Thus, the prototype AA story, though no doubt very helpful to many people, only mirrors the experiences of a minority of people with drinking problems. The experience of Gunvor, a young woman I met at the Link, is illustrative of the struggle to fit in:

> *«I went to AA meetings for the last time in February 97 and then I returned in May 99. Reading the Big Book was a relief for me, and I went to meetings regularly for three months. During that time, I became increasingly self-analysing. I still had a lot of restlessness and anxiety in me – I hyperventilated, was angry and upset. I thought everybody else was perfect, that it was only I being wrong. I insisted on taking the programme, so I could be like them, and at the same time, I began to hate going to meetings. I changed my gesture and put on a facade, before I went down the stairs to Ryesgade [the meeting room]. It was like putting on a mantle. I began to speak the language, so that people outside AA did not understand me at all. I took the fourth and fifth step (3) with my sponsor and I couldn't understand that I didn't experience the kind of happiness that everybody else described. On the contrary, I was sad, I cried a lot, and I was very anxious. Everything went wrong, when I had to tell my story. Afterwards, I felt down, and I thought, why don't they mind their own business? Why do they have to know about the four times I have been raped? So, they can have something to talk about? Is it really so, that I have to rake all this up? Three weeks later I broke down completely. I knew, I just had to get away from AA – I had to be de-programmed. I had been hitting myself on the head with all sorts of ideas about not being grateful enough, and I just couldn't grasp the unity of AA.»*

In therapeutic settings narratives work as means of socialisation and resocialisation provided by institutions such as treatment centres or mutual aid fellowships like AA. The institutional setting forges a narrative asymmetry, which defines the entitlement to narrate and the role story telling is supposed to play in social interaction. Institutionalised master narratives prevail in all educational, religious, and medical settings, and although as an organisation AA is none of these, in practice it draws on the same elements. While the first three steps of the AA programme focus on surrender, the fourth and fifth steps have a confessional character.

In his writings, Foucault has demonstrated a strong association between prohibition and the incitement to speak as a constant feature of our culture. His effort to sketch out a history of the different ways that humans develop knowledge about themselves in Western societies draws attention to what he calls the "truth games" related to specific techniques that human beings use to understand themselves. One of these techniques refers to the technologies of the self, which permit individuals to effect a certain number of operations on their own way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality. He also points out that these technologies of the self are often closely related to another set of technologies; namely the technologies of power, which determine the conduct of individuals and submit them to certain ends or domination (Foucault 1988:18).

In the history of Western culture, to know you play an important role in taking care of yourself, and one of the techniques of doing so is self-analysis, examination of conscience, and confession. In Christian confessions, the penitent is obliged to memorise laws in order to discover his sins. Since the transformation of self is a means to achieve salvation, the process is closely related to ideas of truth, dogma, and canon, and thus implies an acceptance of institutional authority. One has to bear witness against oneself, and hence the truth obligations of faith and the self are closely linked together. Exposure and disclosure of the self is a way of rubbing out the sin by revealing the sinner.

Religious confession is predicated on the principle that human beings must divulge their sinful acts and thoughts to avoid damnation, and the AA moral inventory of the fourth and fifth steps closely parallels this purpose. Although all activity in AA is, and should be, based on a voluntary will to stop drinking, social pressure – as an aspect of most social interaction – is clearly involved in many cases, such as the ones cited by Gunvor above, for example. Though her experience of forced confession represents an extreme form of curtailment of narrative expression; the inherent asymmetry of story telling is unavoidable. Given that narrative mediates self-understanding and that narratives are interaction achievements, the role of primary recipient is highly consequential. The primary recipient is positioned to provide feedback on a narrative contribution, for example, to align, to embellish or to ignore. Gunvor was first led to revise her story content to secure acknowledgement, but later on chose to search for another, more responsive recipient. Thus, narrative practices reflect and establish power relations in a wide range of settings, and are critical to the selves that come to life through narrative (Ochs and Capps 1996:34).

Counter-versions of a story may arise in the immediate aftermath of a telling or they may emerge long in the future, but they do not necessarily involve overt reference to a another master-narrative: it is the voicing of a disjunctive reality itself that constitutes the counterpoint. Like Hans, Gunvor seems to stage her counter-version by telling about childhood experiences and family relations:

> *«The first six years of my life I stayed with my grandparents. Their home was full of love and I felt good and safe there. My mother is herself child of an alcoholic and she is insensitive. My father is an alcoholic, too, but I did not realise that until lately, and he still manages to have a job. Both of them have always drunk heavily, especially at parties, and they would always be an embarrassment to me. My mother was moody, and you never knew what to expect, so I did not like to bring other kids home. I guess she suffered from some kind of co-dependency and she is still of unsound mind. My home in general was characterised by insensitivity. My parents could go for weeks without talking to each other. My mother was cold and my father was a wimp!»*

In forging story elements into a plot, narrators build a theory of events. The theory at stake here is based on the personal experiences of growing up in a family with tense and problematic relationships, and it suggests that the patterns be carried on as biological as well as social heritage. The story may be seen as a means for probing and forging connections between unstable, situated selves, and an attempt to identify life problems, how and why they emerge, and their impact on the present. As such, narrative allows the narrator to work through deviations from the expected within a conventional structure. Whether or not the narrative offers a resolution for a particular predicament, the therapeutic function lies in the dialogue, action and reflection that expose narrators and listeners to life's potentialities (Ochs and Capps 1996:29). Confessional narratives may not bring the expected redemption for the individual teller, and the truth games played with others always expose the protagonist with the risk of the very same truths being turned against you. However, confessional stories can be countered by other stories, implying theories of events that carry cultural legitimacy and explanatory power to cope with present situations.

Contingency

The last kind of narratives that I would like to present here are also the least organised. These stories are not success stories and they do not share the dramatic plot structure of the AA stories. Neither do they attempt to explain very much. They do not have a clear point, and their lack of temporality, intentionality and plot challenges the basic definitions of narrative. If anything, temporality in these stories is characterised by the burdens of the past; a cyclic time in which the past is evoked again and again, causing repeated suffering, as Els van Dongen described for the lives of people with long-standing mental illness (1997:100). Such "failed stories" leave the individual without perspective and little hope for a better life. They also run the additional risk of leaving the listener wondering why anyone bothered to tell them, as noted by Garro and Mattingly: if the audience doesn't know why the point matters to them, if the events in the story never touch them, then the story doesn't work (2000:3). Although reluctantly told and rarely listened to, these incoherent stories are perhaps the most common among people at the margins of the treatment system. Indeed, the very lack of motivation and agency on the part of the narrator seems to play an excluding role for these people when it comes to treatment options. Many of them are considered rather hopeless cases and referred to Antabus® treatment on and off for years without any specific plan or intended outcome (*cf.* Järvinen 1998). They have more in common with the homeless "struggling along" in Desjarlais' study and the mentally ill in van Dongen' study, than with the patients of occupational therapy, described in Mattingly's study. Keld, who sometimes serves as a volunteer making coffee and talking with newcomers at the Link, presented one such story to me:

> *«I've always drunk, all of my life, the last 40 years. Well, before I used to have a job, different jobs, perhaps a few years at a time, but at some stage things would go wrong, I was often fired, and that was of course due to my drinking. There have been breaks in between. I've been taking Antabus® for some periods. I can't remember when I first started on Antabus®, but I've often had a glass of pills standing at home, so I could take some, when I needed it. Usually, I have just managed by myself. However, I can hardly tolerate alcohol anymore. My liver only works with one third of its capacity [...] I don't know why I drink – boredom, I think, and then to get some sleep. It's not that I go to bars. That was before, perhaps ten or twelve years ago. Since then, I have been drinking on my own [...] I've always known that I drank too much. I haven't always thought of it as a problem though, but I've always known that it differed from others and that the way I drank was wrong or not normal [...] I've never had a plan made for my treatment, it's just something I've been taking for periods of time.»*

Stories like Keld's seem to consist of fragments of time with no inner coherence, characterised more by contingency than by directionality and plot. They are not utterly sad –Keld for example sees his ex-wife, who is also a member of the Link, and the two of them occasionally go on holidays together. He also has a granddaughter that he is very fond of. Nevertheless, the story he present for me does not belong to the same genre as the AA story or other illness stories often discussed in the literature on narrative. The struggle for personal coherence and development, the explanatory efforts and the intentions cast for the future are neither explicitly stated nor easily identified. Nevertheless, like the stories told by Hans and Gunvor, Keld's story also touches upon notions of descent and heritage. Without making much of it, he states:

> *«My farther was also an alcoholic, so I was raised with abuse, but fortunately my two kids haven't become so [alcoholics] almost to the contrary!»*

In contrast to the fundamentalist perspective prominent in many AA narratives, offering a clear plot and a well-trotted path for recovery, the relativistic perspective lends room for paralysing indeterminacy. Contingency and the absence of order in these narratives leaves them open for different interpretations, without drawing specific conclusions. The story is characterised by conditionality and subjunctivity (Good 1994:153, Whyte 1997:24), passing the quest for meaning on to the listener. The tools to make sense of it lie in the vague hints at cultural notions and theories of events implicit in the very choice of content. What is told contains the message *sui generis*. The story as such provides no soothing coherence and no path for change.

Nature or nurture

Narratives are not solely shaped by or told in therapeutic settings. Everyday life is full of communicative activity in which narrative plays an important role as a way of articulating shared meanings. If we are not to lapse into solitude or solipsism, we need scenarios and symbols with which we can identify, stories which speak to the things we have in common. Whether or not an account or a theory rendered gains currency partly depends on whether it is informed by a meta-narrative a partly hidden story which is, in effect, the story which the group who bestows this acceptance wants to hear about itself (Jackson 1996:39). Stories of descent and heritage, as issues addressed by practically everybody, may be seen as such a meta-narrative.

Efforts to position yourself in time and space are general features of life stories and identity building, but the particular mode of stressing descent and heritage seems to play a special role in stories of mental, emotional and social problems. While the most common theme seems to focus on the relations to and between parents – I have already mentioned the story of "the strong mother and the weak father" – another common theme deals with the position as a child in the family. Different values may be attached to the specific position and role – positive or negative – the point apparently being the significance of identifying a particular role and the problems attached to that role. Stories about being "the black sheep of the family" or "the perfect child" who has to carry the burden of hopes and expectancies for the whole family's future on his or her shoulders, are well-known and acknowledged as legitimate cases of social heritage. Finally, stories about traumatic events, which seem to change life forever, are also very common in narratives of addiction.

In Denmark, a certain cultural tradition for stories of nature and nurture may have left its traces. Everybody knows, of course, Hans Christian Andersen's fairy tale about the ugly duckling, stressing the inherent and hidden values of biological descent, but the moral of this story is often far from the experiences of ordinary people. Their lives seem much more influenced by the persisting patterns of social relationships. Particularly after the Second World War, the concept of social heritage has become a modern counterpart to the tenacious medical focus on genetics. A general awareness of social heritage has been generated through public debates by prominent and popular researchers and practitioners in the fields of social medicine and children's health like Sven Heinild and Vagn Christensen (Christensen and Brockenhuus-Schack 1997). It is broadly acknowledged that problems of abuse are often related to problems of neglect or poor development in early childhood. Unhappy life circumstances, poverty, poor living conditions; social and family-related problems are considered common signifiers in the lives of many people with drinking problems. These may be important factors in the recurrent references to descent and heritage in personal stories of addiction, and may also account for some of the pessimism reflected in treatment.

According to the narrators, the stories of descent and heritage are not told for their explanatory value, but rather for their significance as context. Notions of descent simply seem to belong to the genre of telling a personal story. Moreover, they provide a sense of existential grounding, a feeling of social origin and belonging, which – in spite of the unhappy circumstances – is preferable to a sense of unattached free floating in the world. References to descent anchor the present in the past and give a sense of continuity – if not coherence and directionality – which is basic for narrative as a genre, lived as well as told. Finally, ideas about heritage provide identity and in this sense also legitimacy to the present situation. The process of recovery from alcoholism is often an uncertain and unstable one, the chances of relapse are always present, and there is no guarantee of a cure. In such a situation, references to the forces of nature and nurture may be both helpful and appropriate.

Conclusion

Multiple layers of meaning stretch out a safety net underneath the institutionalised versions of reality by providing alternatives when the interpretations chosen first seem to fail. As I have tried to show, narratives may have fundamentalist tendencies with an almost magic character of conjuration or invocation. Confronting the "demon" by the mere voicing of a dangerous utterance or the telling of a scary story is expected to protect the individual from further atrocities and prevent the fearful events from recurring. Other narratives work like confessions, which may provide cathartic relief through the open expression of strong feelings -again with the implicit idea, that damnation can be avoided through exposure and sharing, and yet others seem to build merely on the contingency of various circumstances. However, whether fundamentalist or relativistic, narratives are inevitably open for negotiation, they can be contested and usually are so by the narrators themselves. They may adhere to a dominant theory of events, but they usually draw on multiple layers allowing alternative versions to be voiced. Questions of nature and nurture can be and have been invoked to legitimate very different worldviews, but the existential significance of descent and heritage seem to be universal.

The personal stories told by people who are recovering from alcoholism through the Minnesota Model treatment and the AA programme, through the medical treatment with Antabus® or by spontaneous remission, reveal a broad spectrum from highly structured success stories at one end of the scale to a remarkable circularity and absence of narrative plot at the other. While the ethos of therapy in general may be less positive in Europe than in America, I also think that a preference for meaning-centred approaches and stories of intentionality in the analysis of illness narratives might be at stake in anthropology. Certainly, such a bias plays a role in therapy. The value of personal development and integrity seems to be taken for granted as a natural goal *per se*. Success stories are much easier to identify as narratives, they are often well structured with clear endings, and – perhaps most importantly – they are gladly told! However, if narratives are necessarily intentional and head towards desirable ends there is no room for the many stories with dead ends, for the circularity and meaninglessness of repetition, for all the unsuccessful stories, all the tragedies. This, in turn, means that they are left out as if they were not even worthy of being told.

The new behavioural medicines only add to the muteness and marginalisation of people with weak stories by trying to rationalise and reduce their accounts to therapeutic techniques. In fact, the less successful stories are there, lived if not told, and though they may appear plot-less, they are not point-less – their moral stressing the persistence of social heritage and the contingency of individual lives.

Notes

(1) Data are drawn from two related research projects, the first on Minnesota Model treatment carried out in 1990-93, the second on reform movements, medicines and spontaneous remission carried out in 2000. The first project was funded by Rusmiddelforskningsinitiativet, Socialstyrelsens udviklingsmidler and Sygekassernes Helsefond, the second by Sundhedsstyrelsens Alkoholpulje and Sygekassernes Helsefond, all of which I thank for their support. I would also like to thank the many people from the treatment centers involved, who willingly participated in these studies and shared their experiences with me: Heliosfondens Skovgårdshus, Alfa Behandlingscenter, the Link in Copenhagen, and groups of Alcoholics Anonymous. Finally, I want to thank participants at the MAAH conference in Tarragona 2001, particularly Susanne Reventlow and Helle Johannessen for their useful comments on an earlier version of this paper.

(2) The effect of antabuse (tetraethylthiuramdisulphide) was discovered in 1947 by two Danish researchers, Jens Hald and Erik Jacobsen, at the biological laboratories of Medicinalco in Copenhagen (Hald and Jacobsen 1948). The story goes that they were working on the potential of the drug disulfram in the treatment of worms, and to test its toxicity they ingested small amounts of the substance and found out that it had serious adverse reactions on alcohol (White 1998:226).

(3) The fourth and fifth steps are often referred to as the confessional steps.

(4) Made a searching and fearless moral inventory of ourselves.

(5) Admitted to God, to ourselves, and to another human being the exact nature of our wrongs (AA 1990).

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 47-70

HIV, mortality and the self

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Introduction

As some observers have noted early on, the HIV/AIDS pandemic has, since its emergence in 1981, «touched on almost all aspects of society» (Fineberg 1988). In a first sense, this means that this condition is «an extraordinarily useful sampling device» for the social scientist (Rosenberg 1989): it provokes reactions, which make the constitution of social reality visible with particular clarity, thus constituting a valuable analytical tool. In a second sense, it means that AIDS may «also *reshape* many aspects of society, its institutions, its norms and values, its interpersonal relationships, and its cultural representations» (Nelkin/Willis/Parris 1991: 2). HIV "touches on" society in this double sense of having analytical and – potentially – substantive effects.

In the following, I will apply this general line of inquiry to the contemporary Western form of subjectivity. By relating the three concepts mentioned in the title to one another, I should attempt to shed light on the contemporary form of subjectivity – i.e., the historically and culturally specific manner in which contemporary Western individuals may establish a sense of identity. The analysis of biographical narratives by people with HIV/AIDS will be used as a tool in order to gain insights into the state of contemporary subjectivity. The close association of HIV with the prospect of finitude will be crucial for this condition to assume the status of a privileged analytical tool regarding the contemporary Western self.

My knowledge and methodology, as well as some of the terminology used in this article (including the very concept "*form* of subjectivity"), are inspired by the last period of Michel Foucault's work, namely, his research on historically and culturally specific experiences of sexuality (Foucault 1984a, 1984b). The idea is to grasp the *historical a priori* of basic human experiences – i.e. the cultural and historical specificity of the framework for making these experiences, which is generally taken for granted in a given society. For a more detailed description of the way in which the research presented in this article is inspired by Foucault's work, please refer to a recently published monograph (Rinken 2000).

The argument that I will develop entails a rather straightforward – if implicit – statement regarding the contribution of medical anthropology to general anthropology. Let me anticipate this statement in an explicit fashion. I suggest that research on the ways in which contemporary Western individuals can make basic human experiences, such as disease and mortality, constitutes a crucial contribution to the reflection on the contemporary Western way of being. I consider such self-reflexive inquiries on the historical and cultural specificity of contemporary society to be, in turn, the intellectually most challenging task of the social sciences in general and anthropology in particular.

In the following, I will first discuss the nature of life with HIV as an experience of mortality. In a second step, I will explore the relationship between historically specific forms of subjectivity, on one hand, and the strong awareness of a limited life expectancy, on the other. Third, by discussing two exemplary cases, I will present the empirical results of the research that matter most in the context of the argument presented here. Finally, I will bring the basic conceptual elements of this research (HIV, mortality and the self) together by suggesting a "diagnosis" of contemporary Western subjectivity.

To avoid misunderstandings, I would like to make a few remarks about the sense in which I refer to death, mortality and finitude throughout this article. The privileged role granted in my analysis to this aspect is not meant to imply that it is the only one that matters for people who live with HIV/AIDS. Other highly relevant problems include the possible stigmatisation of HIV's main transmission practices and the endurance and management of the manifold afflictions, which may hit the infected. I have applied a selective research strategy, rather than aiming at an exhaustive description of life with HIV. In addition, my emphasis on mortality is not to be confused with the notion that, within a time frame still to be defined more precisely, all or almost all HIV-positives are to die. Terms such as "mortality", "the problem of mortality" and "the prospect of finitude" have nothing to do with mortality rates as such; they are used as synonyms of "the *thought* of mortality during lifetime".

To some extent, the problem of death will thus remain abstract throughout this article. In my use of the term, "experience of mortality" does not refer to the process of dying, i.e. the last weeks or days. Rather, it refers to the recognition of having to die *some day* – with this day being expected or feared to arrive *too soon*. Admittedly, the distinction is fragile. Yet, the recognition of one's own mortality during lifetime is irreducible to preparing oneself to actually die. The experience of HIV-positivity is special in this respect. Other conditions which evoke a strong awareness of mortality, such as diagnosis of advanced-stage cancer, are likely to cause death within a much shorter time-span than that which people with HIV have, on average, after having been intensely confronted with the prospect of their own finitude. As compared to people affected by fatal epidemics of the past (such as influenza or the plague), people with HIV typically have relatively more time «to reflect on their condition» (Ryle 1992).

HIV as a symbol of mortality

Since the introduction of anti-retroviral combination therapies in the mid-1990s, HIV infection has increasingly come to be perceived as a chronic, manageable condition – to the extent, that is, to which those treatment options are available to the affected. The Vancouver AIDS Conference in 1996 constituted a benchmark in terms of establishing "Highly Active Anti-Retroviral Therapy" (HAART) as a viable treatment option. In order to avoid a misled notion of HIV now being fully "under control", it is of course important to be aware of the clinical limitations that the current treatment offers. These include the possibility that the Human Immunodeficiency Virus may develop resistance against one or several of the components of a drug "cocktail" (potentially triggering a dramatic decrease in treatment options), that the drugs' effectiveness may diminish in the long run, or that their toxicity may cause intolerable side-effects. In addition to this note of caution, it is also important to stress the geographical limitations of combined anti-retroviral therapy. As is well known, the lack of basic medical care, not to mention huge problems in making these extremely expensive HIV/AIDS treatments available to developing countries, is bound to contribute to the perpetuation of the devastating impact of this disease in large parts of the world, especially in sub-Saharan Africa. That said, however, it seems likely that the current trend toward a substantial improvement in treatment options and, subsequently, the affected people's life expectancy, will – in industrialised countries – result in removing the "death sentence" image that was initially attached to HIV and AIDS.

Throughout the first 15 years or so of the pandemic, though, HIV/AIDS unquestionably constituted a powerful symbol of mortality not only in developing countries, but in Western industrialised society as well (to which the observations contained in this article are limited). At present, this symbolic dimension is in the process of being re-established as a boundary between the highly industrialised and the so-called developing world. In the pandemic's early years, however, this boundary primarily divided social groups within Western society from one another. The initial emphasis on the link between practices that are limited to specific subgroups of the population (such as drug injection or homosexual intercourse), on one hand, and the risk of getting infected, on the other, provided much-needed reassurance to the wider population regarding their own vulnerability. For at least the first 15 years of the pandemic, the close association of HIV and AIDS with death and dying clearly was one defining factor for the relations between the affected and their social environment. The symbolic status of this condition as a synonym of premature death affected the social relations of the HIV-seropositive in many ways, including the fear of disclosing one's serostatus to family, friends or colleagues, and the manifestation of unhelpful or even negative reactions to such (deliberate or, at times, involuntary) acts of disclosure. While the social science literature generally describes these phenomena as caused by the manifestation or fear of moral stigmatisation in relation to HIV's main transmission practices, they can all result primarily or even exclusively from HIV's association with premature or even imminent death (Rinken 2000, 161 ff.). Even in special social environments such as self-help groups, created explicitly by and for HIV-positive people in order to protect themselves against discrimination and to provide mutual support to one another, a "hierarchy of mortality" in relation to immunological markers of disease progression can be observed (Rinken 2000, 113 ff.).

More important still in the context of the argument presented here, the close association of HIV with human mortality also tended to determine the perception of an HIV positive diagnosis on the part of the individual receiving the news. Throughout the pandemic's first 15 years or so, when receiving a "positive" HIV antibody test result, the affected individual typically felt that her or his life expectancy had suddenly diminished dramatically; in many cases, he or she even expected imminent death.

Apart from similar findings in other studies, this is what happened to almost all the people interviewed for the research project the results of which are reported here. In the spring of 1993, I conducted in-depth interviews with 21 individuals with HIV or AIDS based in Florence or Milan (Italy), including men and women from all relevant transmission groups (1). My interviewees' age at the time of diagnosis ranged from 19 to 48 years, and the year of diagnosis ranged from 1983/4 to 1992 (with twelve cases diagnosed in 1987 or earlier). From indications given in the course of the interviews, I can infer that more than two-thirds of my respondents had been infected with HIV for at least five years before the time of interview (2).

This study is thus situated at a precise point in the history of the HIV-pandemic: the fieldwork was conducted before the development of HAART. With just one or two exceptions, my interviewees shared the social perception of HIV/AIDS that was dominant at that time, intimately linking this condition to the prospect of finitude. Before receiving the diagnosis, my respondents had (again, with just a few exceptions) also shared the generalised confidence of living on to old age that, according to many observers (e.g. Ariès 1974), has contributed to turning death into a "taboo topic" in 20th century Western society. In combination with their youth (two-thirds of my interviewees were between 19 and 29 years old when receiving the diagnosis), this taken-for-granted nature of longevity made the sudden confrontation with the prospect of premature death all the more traumatic.

The event of diagnosis hence constituted a (indeed, usually *the*) crucial turning point in the lives of my interviewees. Due chiefly to its initial association with imminent death (3), the diagnosis of HIV marked a clear distinction of a "before" and an "after" in their lives. In reaction to the first question (which was the same in all the interviews), namely, the request to tell me something about life before HIV, almost all my interviewees established a biographical narrative structured in terms of the difference between the *before* and the *after*. Almost all my informants had perceived the diagnosis of HIV as a watershed event, a perception that they recounted in reaction to my initial question. The interviews conducted for this research permit the identification of five modes of self-constitution as mortal beings – five ways ("ideal" types in the Weberian sense) of relating the periods *before* and *after* diagnosis to each other. These are invalidation, reinforcement, switch, void, and continuity.

The "invalidation" and "reinforcement" patterns potentially form a sequence – yet the development from the first to the second is by no means automatic. Representatives of the invalidation pattern report a lasting loss of the self, which had characterised their life before diagnosis. Representatives of the reinforcement pattern had perceived a similar loss of self as an immediate effect of diagnosis – but they have since overcome this crisis by re-connecting with that previous self-definition and accepting it as again valid, which develops a sense of continuity with the period preceding diagnosis. Most of my respondents by far belong to these two patterns, defined by a sharp contrast between the *before* and the *after* and a strong desire to retrieve key elements of that *before* (a desire that is accomplished in the reinforcement mode). Many "reinforcement" interviewees had got in touch with a self-help group soon after receiving the diagnosis; in many cases, their identity work as an HIV-positive person is related to a shared group identity as homosexual men.

Specific background experiences may lead to particular experiences of diagnosis. While the loss of one's old self-triggered by the diagnosis of HIV is usually (as in the invalidation and reinforcement patterns) deeply regretted, it may actually be welcomed by the affected individual especially if the lost aspect of self was valued negatively even before the diagnosis. The sudden *switch* of a central aspect of the old self-definition to its contrary is thus fully acceptable and constitutes the basic structure of that individual's biographical narrative. A second contrasting pattern (*void*) may result from prolonged intravenous drug-use, especially when it had constituted the sole centre of conduct throughout youth and young adulthood. The knowledge of HIV-positivity may then enhance the feeling of emptiness left by that habit and not the loss of a highly cherished self; the individual is confronted with the perception of lacking a distinctive self-definition. Finally, while most of my respondents spontaneously associated the knowledge of having HIV to the prospect of imminent death, some conceived the development of their self as continuous across that moment: diagnosis does not constitute a biographical watershed here. Among my interviewees, the exemplary case for the *continuity* pattern is a person with haemophilia: life-long experience with this disease had taught him not to anticipate potential future distress, but rather wait and see.

My use of the research interview as an analytical tool with a view to contemporary Western subjectivity relies on the combination of two crucial features of the HIV experience. Speaking in general terms, HIV combines an extraordinarily strong association with the thought of mortality at the time of diagnosis and a relatively long time of survival afterwards. Relative, that is to say, not only to the affected individual's expectations immediately after diagnosis, but also to other medical conditions that are commonly classified as terminal. While it is possible, after the initial shock, to retrieve some trust in the future and to again develop plans and projects, the idea that you may be *running out of time* is bound to persist. For the generation of people with HIV/AIDS represented by my interviewees, the future never quite recovers its previous taken-for-granted quality. Even while recovering the strength to engage in projects with a prominent future-dimension, the individual has to render his or her self-definition compatible with the possibility that death may be close.

Awareness of mortality thus has to find a place within the affected individual's self-construction – in a double sense. First, the biographical self-construction that is established at a given time can be sustained as valid only if it is compatible with the possibility that there may not be enough time to substantially review it in the future. Otherwise, any reminder of one's finitude may cause depressive crises due to the contrast between that self-definition and the thought of mortality – and life with HIV abounds in such reminders. Second, that self-construction has to accommodate the effects of the event which first provoked the intense awareness of finitude (namely, as a rule, the diagnosis of HIV). For individuals living with HIV or AIDS, the challenge of biographical self-construction is constituted by this double matrix of lasting awareness of finitude, on the one hand, and past disruption (if diagnosis was indeed perceived as a disruptive event), on the other.

I suggest that the combination of these two features constitute a vantagepoint for the analysis of contemporary Western subjectivity. To make this point plausible, I will now briefly outline the current sociological debate on the contemporary Western self. Building on essential contributions *to* and some observations *on* that debate, I will then return to the question why I consider the biographical narratives of people with HIV to be an excellent basis for making observations regarding the contemporary Western self.

Biographical self-construction in contemporary Western society

In recent years, a large number of sociologists and social psychologists have contributed to the debate on the state and development of subjectivity in contemporary Western society. The ongoing discussion on the self is imbued with concepts such as fragmentation, fluidity and reflexive construction. Its empirical basis is the observation that, in order to function within an increasingly fragmented and unstable world, the self has in turn become increasingly fragmented and unstable. As a result, the classical modern conceptualisation of the self as based on a sense of continuity and coherence in relation to personal attributes (4) is being received with growing scepticism.

In a range of literature commonly labelled as "post-modern", the self is described as a chameleon that consciously selects both professional and private commitments; the lifetime perspective is dissolved into a loose sequence of selves. This "post-modern" conceptualisation relies on the assumption that the self's malleability includes the future. In addition to the idea that individuals fashion themselves regardless of past commitments, it is assumed that the self is "liquid" also with a view to the possibility of future revisions, taking for granted that any element of the present self definition may be changed when appropriate. A similar assumption is made by leading representatives of the alternative school of thought, which defends the idea that the contemporary self preserves some nucleus of perceived coherence and stability. Even these latter authors assume that the self has to adjust to the increasing flexibility and complexity of the social world by becoming in turn increasingly flexible and multi-faceted. Self-construction is supposed to proceed by means of "biographical incrementalism" (Schimank), i.e. the temporary adjustment of one's self-definition to largely contingent life situations. From the outset, such "incrementalist" self-definitions are established with a view to the possibility of their future revision.

For the assumption of future malleability to be tenable, however, people need to be confident that they will have a rather long span of life ahead. This is a blind spot of current theories of the self: a basic point that is taken for granted. This blind spot is characteristic not just of the contributions by advocates of the post-modern self, but of the whole debate. The current debate on the self does not address the issue of how the awareness of a strongly limited life expectancy may affect the self-construction of contemporary individuals; it neglects the finite nature of life. Even those authors who come relatively close to addressing the problem of biographical self-construction in the awareness of mortality, such as Zygmunt Bauman and Anthony Giddens (to mention one representative of both the "post-modern" and "late-modern" camp, respectively)(5), fail to take the prospect of mortality seriously.

In his *Mortality, Immortality and Other Life Strategies* (1992), Bauman distinguishes between a modern and a post-modern way of confronting life and death, which generate distinct types of selfhood. According to Bauman, transcendence of the human being's finite nature is a necessary prerequisite of any cultural creation. This is to say that mortality is *the* constitutive feature of social institutions and cultural creations – yet this generative power is most forceful «precisely when we manage to live *as if* death was not or did not matter» (Bauman 1992: 7). All meaning is due to our condition as mortal beings – yet it relies on this truth being bracketed: «Memory of illegitimate birth must be erased if noble life is to be practised with ease» (Bauman 1992: 8).

This being the general situation, specific strategies of forgetfulness are employed in different periods of history. As Bauman argues, modernity de-constructs mortality into a multitude of afflictions that can potentially be dominated by science – whereas in post-modern time, immortality is de-constructed into a multitude of achievable satisfactions. In modernity, the ultimate threat vanishes from view as a result of its de-composition into the failure of specific organs. In post-modern time, by contrast, «the ultimate perfection may dissolve and vanish from view» as a result of specific moments of happiness: «Immortality is as nomadic as the nomads it serves.» (Bauman 1992: 164) In biographical just as in historical time, the modern obsession with continuity and coherence is giving way to a new condition: the post-modern nomad constructs his or her identity «until-further-notice» (Bauman 1992: 167). Life turns into a series of unconnected experiences: the past no longer binds the present, just as the present ceases to bind the future. As Bauman suggests, the only lasting feature of post-modern identity is its transitory nature: the self is experienced as a sequence of potentially reversible transitions.

Turning to a social theorist who believes that the contemporary Western self represents the full development of tendencies inherent in modernity, Anthony Giddens' *Modernity and Self-identity. Self and Society in the Late Modern Age* (1991) contains an account of the relationship between contemporary institutional developments and the mechanisms by means of which individuals attempt to generate a sense of personal coherence and direction. The contrast between Giddens and the post-modernists is not semantic: Giddens stresses that a sense of continuity and unity remains a defining feature of self-identity even in post-industrial society. Yet such a sense of coherence is not an objective quality – it is the result of an ongoing process of assessment. Just like all other sorts of knowledge, self-identity has become a reflexive enterprise:

> «It is not a distinctive trait, or even a collection of traits, possessed by the individual. It is the self as reflexively understood by the person in terms of her or his biography.» (Giddens 1991: 53).

While self-definition in terms of status positions or stable social roles was common in static societies, modernity has turned the individual's own lifetime into the main entity in relation to which self-definitions may be established. This ongoing process of biographical self-construction takes place in an institutional environment characterised by the dissolution of cultural traditions, the pluralisation of life-worlds and lifestyles, the generalisation of doubt with regard to the validity of any sort of knowledge, the mediation of experience, and the generalised awareness of multiple risks. The aggregate effect of these factors on the late modern individual, Giddens argues, is an exacerbation of the reflexive nature of the self-process. The multiplication of contexts, choices and potential calamities fosters a growing concern for self-construction in terms of one's life-trajectory, a growing concern with the reflexive planning of one's own life.

Matters of life and death hence play a central role in Giddens' account of modern subjectivity: the very concept of life-trajectory implies life's finitude. Yet, the conscious reflection on one's own finitude does not take on systematic relevance for his analysis of the late modern self. As employed by Giddens, the concept of life-trajectory conceives the future as a horizon of possibilities, rather than taking finitude into account as a potential limit. Knowledge, it has been said, has taken on a hypothetical, "until-further-notice" character in modern time – including the knowledge that an individual may establish about his or her self by way of biographical self-construction. In any given moment of self-construction, Giddens' late-modern self establishes his or her sense of identity only provisionally – in the belief, that is, that the present construction may be revised in the future. Acute awareness of finitude is at odds with this premise.

Current theories of the self assume that the individual can take an extended future life for granted. To some degree, this assumption simply reflects the unprecedented average life expectancy in contemporary Western society. Yet, as we have seen above, this assumption is untenable for people with HIV or AIDS as long as this condition still represents an extraordinary existential crisis for the affected; put cautiously, it has been untenable for the generation of affected individuals represented by my interviewees. From the perspective of people with HIV, the future's uncertainty has to be taken into due account. There may be no time to establish a different construction of self.

From the contrast between ordinary people's confidence in a long life expectancy, on one hand, and the situation of people who have received a "terminal" medical diagnosis, on the other, one may conclude that a biographical self-construction established in the absence of such confidence is too existentially distinct from the general frame of experience to allow for observations regarding a given culture's *form* of self-construction. I suggest that this conclusion be misled. Unlike nutrition, for example, awareness of mortality does not constitute a specific sphere of experience as against others; rather, it sheds light on all of an individual's possible experiences.

To use Bauman's formulation (1992: 2), «whenever being speaks of that other, it finds itself speaking, through a negative metaphor, of itself». As long as we speak and think, we are not yet dead. To think or speak of one's own mortality basically means to reflect on one's life and self. This reflexive perspective differs from ordinary people's reflexive construction of self in that the future is far more uncertain (by "ordinary", I mean people who take an extended life expectancy for granted). Yet, people who are acutely aware of their own mortality will still apply their society's specific cultural framework when thinking about their lives. While having to adjust for the future's fragility, the cultural blueprint of their self-reflections is not invented by them on the spot. Rather, when constructing their lives and selves in the awareness of *being mortal*, they enact historically and culturally specific patterns of self-construction that are available to them in their society.

As an alternative interpretation, then, I suggest that in any given society, there is a close link between the experience of mortality, on one hand, and the general form of subjectivity, on the other. At any given point in history, specific circumstances may cause a more or less vast part of the population to develop an acute awareness of mortality. Rather than dropping out of their society's cultural framework by virtue of this heightened sensibility to the problem of mortality, I suggest that they enact that pattern in a particularly clear manner. The self-construction of people who are intensely aware of their own mortality may be extraordinarily revealing with regard to the form of subjectivity that is dominant in a given society. By "form of subjectivity", I mean the historically distinctive sort of self-relations which people may establish when reflecting on their lives and selves.

I would like to illustrate this idea by referring to the Stoic experience of mortality as described and advocated nearly 2000 years ago by the Roman philosopher Seneca. Seneca famously recommended the contemplation of one's own mortality as a spiritual exercise. In his letters to Luculius, for example, he invites his disciple to reflect daily upon the best way of exiting life: «The only goods which are truly enjoyable for their owner are those for the loss of which he has successfully prepared his soul» (Luc. I.4.6.).

By means of exercises of thought such as the contemplation of death, the Stoics sought to raise their existence above the level of ordinary life. These spiritual exercises were designed to rid the mind of bad habits of thought – such as the idea that death may be an evil. Excellence in such intellectual asceticism would bring about one's transformation into a sage – a state as close to divinity as can possibly be aspired to by human beings. Thus, for the Stoics, self-constitution as mortal involves *change* relative to the ordinary condition of their contemporaries. Yet to us, it also reveals a way in which Greco-Roman subjectivity differs categorically from ours. The sage's self was conceived as a reproduction of the divine order of Nature. As Pierre Hadot has stressed, a feeling of belonging to this all-embracing order of the Cosmos constituted, in Antiquity, a necessary condition for any action to be taken on one's self (Hadot 1988: 263). The contrast with the contemporary self's situation is evident: we are neither able to conceive our environment as the eternal Cosmic order, nor our selves as black boxes potentially ready to reflect that order.

In contemporary Western society, the acute awareness of one's own mortality sets an individual apart from the general population in a particularly strong way. This is especially true if young people make that experience. Yet, I assert, precisely this break with respect to the taken-for-granted character of an extended life expectancy provides a precious analytical tool with a view to contemporary Western subjectivity. This is even truer if, as in the case of HIV positivity, the intense awareness of finitude has come about in the context of a highly disruptive life event – namely, the event of diagnosis. When establishing his or her present sense of identity in relation to a biography marked by the event of diagnosis in terms of a *before* and an *after*, the individual has to take account of the fact that life and self could have developed differently in the absence of that event. HIV's double matrix of disruptiveness and lasting awareness of finitude confronts the individual intensely with that paramount problem of modernity, namely, contingency. If the test for HIV serostatus had turned out "negative", the present (including the present sense of identity) could be substantially different. The experience of HIV/AIDS exemplifies and exacerbates the threats posed in contemporary Western society to the perceived coherence and stability of the self.

Due chiefly to its association with finitude, the diagnosis of HIV is bound to shape the individual's sense of self *after diagnosis* in important ways. In retrospect, diagnosis may thus become visible as a contingent event that left a decisive mark on the self. Visible, that is, not just to the social scientist who studies the biographies of people with HIV, but to the affected persons themselves. The crucial question is how this event is related to the individual's present sense of self. What role is attributed to the experience of finitude (and the key event which triggered that awareness) with regard to the overall development of the self?

Self-actualization versus *self-transformation*

To address this question, I will now discuss exemplary cases of the two types of overall effect of the HIV experience on the individual's self that have emerged from the interview material: self-actualisation and self-transformation. For one of these two types, namely, self-transformation, there is actually only one clear example among my respondents – who also happens to be the exemplary case of the switch pattern (6). Interviewee Francesco recounts that, in the context of a dramatic health crisis, his personality changed suddenly and substantially. While conceding that «*usually, you know, the character does not change in just one moment*», Francesco reports that this is what happened to him. His biographical narration is structured in terms of the *before* and the *after* marked by a sudden change of his self – a change to the better in terms of his ability to connect to his social environment.

Let us have a closer look at the event that caused Francesco's change, which happened about ten months after his HIV diagnosis. As further blood work had revealed soon after he first received the news of HIV-positivity, his CD4-count was already down to almost zero; Francesco was thus confronted with the diagnosis not just of HIV, but of advanced-stage AIDS. Francesco says he became scared by the thought of imminent death when, several months later, he got trapped on a remote island without proper treatment for the *candida* which kept him from eating sufficiently (in a previous *candida* attack, he had lost 17 kilos in weight). He also felt intense pain because of an acute infection.

In this context, the key moment in his narration is the collapse of the «*bubble*» in which he had felt to be wrapped up, and by which he felt cut off «*from everything and everybody*», including his lover and his brother, who were travelling with him. His brother told him that, if he felt so bad that he seriously feared to be dying, he should either *react*, or else start to prepare himself for the «*journey*». Francesco reports that this clear-cut alternative «*triggered the change*». Given that he did not at all feel ready to die, he chose "reaction".

> *– «In that moment, I was really scared of being about to die. Because I did not have the [appropriate] medical drugs, I had this candida [in the mouth] which, I said, 'if I lose some more weight there is nothing left', because I was already very slim, you know? So, so, like that (...)* (7)*. Then, once I had succeeded in interrupting that vicious circle, nothing, I started to do well – to do well: to recover, to do better. I started to feel an appetite again, you see. The situation started to turn normal again.»*

> – «Also because you talked?»
>
> – *«Because I started to talk. (\|\|) Because before, I absolutely did not manage to talk (\|\|) about how I felt, you see. It really was as if I had a wall instead of a brain, you see, which means [my brain] did not work, it did not».*
>
> – «A wall toward the others or toward yourself?»
>
> – *«With regard to the others and toward myself.»*
>
> – «Both?»
>
> – *«Both, you see, because as far as I'm concerned, they are closely linked, because I have never been a very eloquent, very open, very, as it is called, extrovert sort of person. I always figured out everything on my own, whereas, in contrast, [in that period], it was, it was like that, I did not even think about anything, you see, I did not even spend my time reflecting on things.»*
>
> – «[Your brain] did not work too much?»
>
> – *«It didn't work any more, no, so both the, let's say ... the critical stance toward myself and the ability to express myself to others were both paralysed. You see? That's a bit, let's say, my experience of before and after, because now, for example, even if usually, you know, the character doesn't change in just one moment, but yes, [now] it is much easier for me to talk with others.»*

Before, Francesco says, *«I have never been a very eloquent, very open, very, as it is called, extrovert sort of person»*. Strikingly, this *before* refers not only to the period immediately preceding the event recounted here (at the time of which he was 46 years old), but it extends to various decades of Francesco's life: *«I always talked little»*; *«there has always been this ... this* handicap *(...), even when I was a boy, when I was 17, 18, 20 years old»*. His sudden change of personality regards not just that acute crisis, but his sense of identity throughout his life.

> *«And I am doing much better, because I am much calmer, more relaxed, you see, – that's to say, almost everything changed, – everything changed, in short, it changed for the better, I have to say.»*

While from the observer's perspective, it is easy to label this perceived change for the better a "secondary gain" that makes his very complicated health situation easier to bear–, the truly striking observation is that Francesco's *past* sense of self comprises all of his adolescence and adulthood up to the age of 46.

Francesco's report thus is a very clear example of the switch pattern – i.e., a neat break between *before* and *after*, without any desire to return to the former. Now, for the purposes of the argument that I wish to present here, it is crucial to stress that this structure of the biographical narrative in terms of a *switch*, on one hand, and the interpretation of that biography in terms of *self-transformation*, on the other, are *not* the two sides of just one coin. In other words, Francesco's assessment of HIV's impact on the development of his self could have been different, despite the basic structure of his narrative in terms of *switch*. In the context of my argument, a crucial feature of Francesco's account is the absence of any indication that he believes to have now finally achieved access to his "true" self, for example by describing his dramatic crisis and change as a "self-revelation". Francesco limits himself to the statement that he has changed suddenly in reaction to the intense dread of death that came about in the aftermath of his HIV-diagnosis. «*There really was a turning point, yes ... Really a remarkable change, as I told you, as compared to how I was before, in short.*»

This matter-of-fact description of successive identities is in sharp contrast with the way in which a variety of other respondents, including representatives of all four remaining patterns of biographical self-construction (invalidation, reinforcement, continuity and void), assess the impact of HIV on their lives and selves. In all those cases, the self-definitions *before* and *after* are distinguished not only in terms of a preference for one of the two (as in the case of Francesco), but a judgement as to their degree of approximation to the "true" self. Before elaborating further on the difference between self-transformation and self-actualisation, let us have a look at an example of the latter.

Giulio is an exemplary case of the invalidation pattern. Just like Francesco, his biographical narrative establishes a neat distinction between the *before* and the *after;* just as in Francesco's case, this distinction is related to contrasting self-definitions regarding his attitude toward the social environment. In the case of Giulio, though, the self-definition that is valued positively is the one that is perceived as *lost*. Rather than accepting his new self, Giulio keeps deploring the loss of his old one – even though, at the time of the research interview, eight years have passed since he first learned, back in 1985, that he has HIV. (Remember: unlike the reinforcement pattern, where crucial elements of the old identity have been retrieved giving ground to a third stage, the invalidation pattern consists of just two stages, with the period *after* diagnosis extending to the present.) When asked to describe his life before the diagnosis of HIV, he recounts:

– «*What comes to my mind?*»

– «Yes.»

– «*A happy-go-lucky attitude.*»

– «Happy-go-lucky?»

> – «*That's a vast notion, right. But what comes to my mind is mainly the, um, ability to face daily problems not in a way ... that is, without this reference to seropositivity. That means very – in a very relaxed way – powerful when facing life situations, difficulties, joys, sorrows, anything in a very – in a devil-may-care attitude. You see?*»
>
> – «Tell me more about it. Maybe you can tell me an episode to make me understand better.»
>
> – «*Well, being happy, perhaps having at times to face negative life situations, you know, but to take them in a matter-of-fact way and so to live as well as possible.*»
>
> – «That's the situation now?»
>
> – «*No, that's the situation before. Do you understand? That is, not to be afraid of difficulties and, for better or worse, if one has to struggle to live, struggle, because it makes part of life. You see? Devil-may-care in this sense of not letting oneself get tangled up heavily in one's daily problems.*»
>
> – «And now?»
>
> – «*Now everything seems very difficult to me, even a small problem.*»

Interestingly, Giulio's distress is not related to any acute health crisis. He has not suffered any of the somatic afflictions that may strike people with HIV; his immunological situation is one of the best among all my respondents. Rather, social relations play an essential role. His decision to be tested was due to the suspicion that he may have caught the virus when having a sexual adventure outside his stable loving relationship. When his doubts were confirmed, he had already passed the virus over to his long-time lover. Rather than placing blame on Giulio or rejecting him, his partner said that he was ready to share this experience, if only their relationship would continue. It is hard to imagine a supportive reaction to such news. Yet Giulio felt so deeply distressed about, as he says, having "*destroyed*" his lover's life that he himself broke off the relationship.

At the time of the interview, Giulio blames himself much more intensely for having left his ex-lover than for having passed HIV to him. He also intensely blames himself for having quit a promising professional career because he was concerned that this job would impede compliance with the medical check-ups that are recommended to people with HIV. Finally, he blames himself for having lost some of his financial independence (having moved back to his parents' home for some time) and for earning his living with low-skill jobs now. These losses are examples of how Giulio has come to let himself «*get tangled up heavily in (his) daily problems*», rather than facing difficulties with ease and strength.

The culmination of Giulio's troubles, though, lies in the fact that he has never dared to disclose himself to a person with whom he thought possible to start a lasting loving relationship. As soon as an occasional sexual relation develops in a promising way, Giulio flees: his inability to disclose his serostatus is proportional to the degree of his emotional involvement. Telling his would-be partner that he has HIV would entail the risk that the relationship may end as a result of the other's rejection. Rather than running that risk, Giulio escapes, thus making sure himself that the relationship will come to an end. He cannot stand the idea of being rejected.

> «Really, my world would collapse, because I, my way of life is closely related to emotional relations, in the sense that they are for me what gas may be for a car, or what electricity may be for a bulb.»

Giulio has entered a vicious circle: he cannot help reproducing patterns of behaviour that add to his distress, which is manifest as insomnia and hypertension. With every missed occasion at establishing a loving relationship, Giulio further fuels the fire of self-blame for «*not having known how to react to this thing energetically*». He himself makes a connection between the destructive manner in which he has come to handle his emotional relations and the events back at the time of diagnosis. His incapability of disclosing himself to a lover toward whom he is developing a close emotional tie is due, as he says, to the fact «*that it has already happened to me*».

On the face of it, this remark may refer to the fact of virus transmission. Yet, if this were the important problem, it would be hard to explain how Giulio can go on having sex with occasional partners without letting them know about his serostatus. I believe that the key to Giulio's current problem lies in his reaction to the diagnoses of HIV regarding himself and his friend, rather than those diagnoses as such. The point is that he did "*not succeed*" in handling that situation in a way which would have been compatible with his old self-image. On this interpretation, he would thus be avoiding disclosure to a would-be lover due to the fear that his partner may react similarly to the way in which he himself reacted when receiving the diagnosis.

Before, Giulio reports, he was capable of facing negative life situations in a powerful, matter-of-fact way, and hence able to enjoy life even in the presence of difficulties and sorrows. When confronted with the news of his and his boyfriend's positive serostatus, this way of conducting daily life «*did not withstand*», as he says further on in the interview. Faced with the news of diagnosis, which he associated with the prospect of imminent death, Giulio felt «*in an offside position in the game of life, you see? Offside in constructing, in making yourself a future*». The crucial difference between life with and without HIV, he repeatedly asserts, regards «*the way in which one lives, and the way in which one poses oneself relative to the problems of daily life*». It is essentially in this sense that Giulio hopes for a return to «*normality*» as a result of future breakthroughs in antiviral therapies (which he expects confidently). This return to normality does not mean life expectancy, but rather «*the way in which one poses oneself relative to the problems of daily life*». At the time of interview, he asserts, his most intense distress stems from the thought that he has irretrievably lost eight years out of the most intense period of a person's life. For eight years in the third decade of his life, normally – in Giulio's view – a period in which people pursue their ambitions with zeal, he has felt to be in an «*offside position*»: «*I have become very timid, much closed, very introverted*».

At the time of the interview, Giulio was wondering whether the lack of strength, which had been manifest in his conduct over the past eight years, reflects his true character. At times, he thinks that his tendency to blame his poor quality of life on HIV may just be an excuse for his own failings: «*because, fundamentally, in terms of my character, I may (have been) much more similar to how I am now when I was 20 years old*». Even before diagnosis, he may already have been far less brave and outgoing than he now likes to think. After having made this remark, Giulio says:

> «*But I say to myself: 'sure. But then, fundamentally, the way I am, as a person I don't like myself.' I don't like myself that way, you see. Whether I have been conditioned by seropositivity, or else I am really like that, it's really bad, you see, because I don't like myself as a person that way (...). But anyway, no, I think that I am influenced a lot by this [i.e. HIV positive serostatus]. I think that if (...) some product [some medical drug] should come up which would make me turn alive again, I don't know, I have eight years of my life – lost, basically. I mean, it's like turning back eight years, you see. Because I feel it, I feel it, within my true personality is repressed.*»

How different this assessment is from Francesco's matter-of-fact observation that there was «*a turning point*» in his life! Although for the better part of a decade, Giulio has not acted the way he would like himself to act, he glorifies that *other* way as the adequate expression of his «*true personality*».

> «*You know, in a sense this thing, you see, it's odd ... maybe it's stupid to say so and stupid to think so, but to have found myself in this very particular, very difficult situation has enriched me incredibly. It has given me the possibility of being so present within myself, so deep with myself, you see, to dig so much within me – yes, it has enriched me a lot (...) And indeed it's very odd, finding a positive aspect, you know, in this whole thing. But, given that I cannot help living this reality, and given that in some way I have arrived inadvertently at reading myself so internally, analysing myself so profoundly, because the reason which has led me to be like this is not a fact of joy, but a fact of pain – but, all told, the result is the same: getting to listen to oneself, know oneself, understand oneself, read oneself as best as possible.*»

The interpretation of HIV's lasting effect on the development of the self in terms of improved self-knowledge is not limited to representatives of the invalidation pattern; among my interviewees, it is also found with representatives of the reinforcement, continuity and void patterns. The specific manner in which such self-knowledge was obtained or aspired to changes from one pattern of biographical self-construction to another. For example, in the case of the continuity pattern, there is a perception of a continuous development toward better self-cognition, while in the void pattern, the individual is struck by the *lack* of adequate knowledge of her or his personal qualities. However, there is a common denominator: the "true" self is supposed to exist independently of the events or experiences by means of which the individual has come to "read" it, as it were. The self is conceptualised as a pre-established text that just needs to be deciphered properly.

Conclusion

Any observation that an individual may make regarding his or her personal qualities is, by definition, self-cognitive. This is true even of the statement "I have changed". That said, we might distinguish two fundamentally different ways in which such observations can be made. The distinction is subtle: it regards the relationship between self-cognition and self-transformation, rather than just juxtaposing the two. On one hand, the self may be conceived as having been decisively shaped by a specific event or experience. On the other hand, the individual may be convinced that his or her basic personal qualities have developed independently of any particular event or experience. In the latter case, any specific circumstances that have altered one's self-definition are conceived as revealing aspects of the self which were present already, but had previously gone unnoticed or had not properly unfolded as yet. The statement "I have changed" (as a result of a given event) is a typical example of the first sort of self-reflections; the statement "I discovered myself" (as a result of a given event) is a typical example of the second approach.

Both types of self-reflection differ markedly with a view to the status of the experience in question. Whenever self-construction proceeds in terms of enhanced self-knowledge, that experience is not conceived to have altered the self substantially. It is thought to have made a difference only with respect to the degree and speed of self-cognition. In contrast, self-construction in terms of transformation proper allows for the idea that, in the absence of that experience, the affected individual's sense of identity would now be largely different.

Similarly, the two approaches also differ with a view to that elusive object of observation, the self. As I have just said, self-construction in terms of self-transformation implies that the affected individual's present sense of identity is the result of particular circumstances. It follows from an event or experience that made a real difference. In retrospect, it is clear that this event may or may not have happened. The individual is aware that her or his present self has come about in reaction to circumstances, which were not necessary as such – they may as well have been different. Therefore, if that event had not happened, the individual's sense of self would now be different. The self 's development is conceived as hinging on contingent events in the individual's environment. In contrast, self-construction in terms of self-knowledge presupposes that the self itself defines the manner in which any possible transformation of self occurs. Particular life-events are thought to contribute, to a greater or lesser extent, to the revelation of personal qualities that are assumed to have existed anyway. Hence, the second type of self-reflection can be termed "self-actualisation".

As I have noted above, both self-actualisation and self-transformation have been observed among my interviewees. Yet, how should it be possible to derive, from interviews with a small group of people with HIV/AIDS, conclusions regarding contemporary Western subjectivity in general? In my interview material, there is a clear predominance of one of those two types, namely, self-actualisation, in terms both of the patterns of biographical self-construction and the total number of interviewees affected. However, in a qualitative piece of research such as this, numerical relations are not a sufficient basis for generalisations. Indeed, any generalisations that may be established because of this research are of a theoretical nature; they do not entail assumptions as to the empirical distribution of the two (i.e., self-actualisation *versus* self-transformation) in a given population.

In this sense, I would like to suggest that an interesting conclusion regarding the state of Western subjectivity can indeed be derived from this research simply by considering a basic quality of the empirical reality on which I have focused. As I have stressed earlier, the experience of HIV/AIDS is typically marked by the combination of biographical disruption, on one hand, and lasting awareness of finitude, on the other. In retrospect, people with HIV have to take the effects of the event of diagnosis for their present sense of self into account. The very fact that contemporary Western individuals may establish that retrospective assessment in terms of self-actualisation is, I believe, highly remarkable. This is especially true for people belonging to the *invalidation, reinforcement* or *switch* patterns, for which the diagnosis of HIV (or related events) triggered a massive change in their self-definition. When interpreting as catalyst of improved self-knowledge a highly disruptive event that may *not* have happened (namely, the diagnosis of HIV and its consequences), my interviewees express the need for an objective principle of order in relation to which they may form their selves.

In traditional societies, people used to turn to such a presumably objective principle of order as a guide for conduct – especially (remember the example of the Stoics) in conditions of heightened awareness of mortality. Contemporary Western society is historically distinct from any other known type of society in that there is no longer an external principle of order whose objectivity can be assumed as indisputable. In its absence, the modern Western individual has to turn to the self as a guide to conduct. Personal qualities have become the dominant source of self-definition. The centre of gravity of the process of self-definition has turned to the individual's own life. As Georg Simmel has put it,

> *«After the individual had been liberated in principle from the rusty chains of guild, hereditary status, and church, the quest for independence continued to the point where individuals who had been rendered independent in this way wanted also to distinguish themselves from one another. What mattered now was no longer that one was a free individual as such, but that one was a particular and irreplaceable individual. (...) (Throughout) the modern era, the quest of the individual is for his self, for a fixed and unambiguous point of reference. He needs such a fixed point more and more urgently in view of the unprecedented expansion of theoretical and practical perspectives and the complication of life, and the related fact that he can no longer find it anywhere outside himself.» (Simmel 1984: 216/1971: 222f).*

Historically, the shift toward self-construction by reference to distinctive personal qualities is a product of «one of the cornerstones of modern culture» (Taylor 1989: 376), namely expressivism. First articulated by the Romantics in the late 18th century, expressivism sustains the idea that we can and shall «find the truth within us» (Taylor 1989: 368). This idea contains a fundamental ambiguity between *making manifest* a truth that is ready to be revealed, on one hand, and *creating* this particular self-cognition as distinguished from other possible definitions of self, on the other. On one hand, the “truth within us” is the object of research and discovery; it has to be articulated and actualised. On the other, the very articulation of that “truth” entails a definition, creation, or even invention.

Thus, the tension between contingent events and the premise of a continuous and coherent self is a basic feature of experience in contemporary Western society. Consequently, the juxtaposition of the classical modern and the post-modern self can be related to my distinction between two ways which the ambivalent relationship of *making manifest* and *making* may assume. The distinction between self-actualisation and self-transformation is a conceptually more elaborate re-formulation of the distinction between a classical modern self and a post-modern self. As I have explained earlier, both types differ most markedly with a view to the individual’s awareness of *being formed.*

I suggest that this difference is crucial. When an individual interprets her or his present sense of self as having been *revealed* by an event which may as well not have happened, the personal qualities which define that sense of self are singled out as fundamental. They are believed to exist independently of that event and prior to any particular event. A “don’t touch me”-status is attributed to them: the self-definitions are considered to be a necessary condition of experience, rather than a result of life-events. In short, these self-definitions are treated as an objective principle of order. For self-actualisation, as distinguished from self-transformation, the individual’s present self-construction assumes the position which, in pre-modern times, was held by supposedly objective, external principles of order, such as the Cosmos. Self-actualisation treats one particular self-definition, or set of definitions, as indisputable.

To conclude, limiting ourselves to the first of the two ways in which the HIV/AIDS pandemic potentially “touches upon” social reality, this condition highlights the tendency of contemporary Western individuals to pursue, in their biographical self-construction, a stability and coherence which their lives and biographies make impossible to attain (8). According to my line of interpretation, the contemporary Western self continues to be more deeply intrigued by the pursuit of stability and coherence than any contributor to the current sociological debate on the self has realised. Rather than following the social environment’s trend toward ever increasing flexibility, contemporary Western individuals seem inclined to turn specific self-definitions into objects of devotion – despite clear evidence, in their own lives, that the self’s development is closely tied to contingent circumstances.

Notes

(1) Eleven of my respondents are likely to have been infected via sex among men (three of these men also injected drugs at some point), whereas six (two men and four women) were doubtlessly infected by sharing needles in the context of intravenous drug-use. One man was infected by blood-products for the treatment of hemophilia, and three women caught the virus when having heterosexual relations with partners whose past drug-use habit (two cases) or whose infection with HIV due to blood-products (one case) was not known to them at the time. Fourteen of my interviewees are thus men, seven are women.

(2) The estimated time of infection ranges from one year and a half to eleven years and a half before the time of interview. With one exception, respondents did not suffer from serious physical constraints due to ill health at the time of interview (although the state of health of a further four interviewees was precarious due to an advanced state of disease progression). At the time of interview, about one third of my respondents qualified for classification as a "person with AIDS".

(3) See Rinken (2000: 56 ff.) for a detailed review of the various analytical elements of the diagnosis in terms of their contribution to biographical disruption.

(4) Charles Taylor's *Sources of the Self* (1989) offers an influential historical account of the modern self's emergence; see especially chapter 21 (Taylor 1989: 368ff.) on the «expressivist turn», i.e. the emergence of self-definition in terms of personal qualities.

(5) For other relevant contributions, see Gergen (1991), Zurcher (1977) and Lifton (1993) for the "post-modern" and Hewitt (1989), Leinberger/Tucker (1991) and Schimank (1985; 1988) for the "late-modern" approach.

(6) There is no necessary relation between any of the two types of biographical self-construction with a view to the overall effects of the experience of HIV that I am going to discuss now (i.e., self-actualization and self-transformation), on one hand, and the patterns or modes of biographical self-construction that I discussed earlier (invalidation, reinforcement, switch, void and continuity), on the other.

(7) For my quotations from the interview material, I shall use the following symbols. Three dots signal a pause, i.e. a temporary interruption of the flux of words. Three bracketed dots signal an omission in the context of just one particular answer given by the respective informant. Three bracketed backslashes indicate that I have composed one quotation from answers to several questions in order to obtain a concise statement on a specific topic without having to document lengthy passages of the interview. In these latter cases, I have always respected the principle of sequentiality: the elements of that composed quote follow each other in correspondence to the actual interview sequence. Square brackets are used when I have added editorial remarks to a quote in order to render it more comprehensible.

(8) The contemporary Western self can thus be called the nihilist self – provided that the term "nihilism" is not understood as the advocacy of moral relativism (as a well-established but misled reading would have it). Rather, the concept refers to a fundamental long-term process in the history of the West, namely, the dissolution of any generally accepted, integrative and supposedly objective principle of order capable of shaping the individual's conduct and self-definition in all walks of life. «This is what Nietzsche calls nihilism, that men continue to pursue in their lives and intelligence what their intelligence and lives make impossible to attain» (Strong 1988: ix).

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 71-85

The integration of the District health system in South Africa.

Negotiating the boundaries between researcher and facilitator

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> «An anthropology of modernity would employ ethnographic holism to dissolve the illusions that convince us the 'we' are modern, unprecedented but objective observers of other people's cultural worlds. As yet such an anthropology hardly exists [...] it would be far more empirically challenging [...]» (Jonathan Spencer 1996).
>
> «The ethics of Anthropology is bound up with ethnography as a discourse of responsibility, in the sense of a discourse of reflexive awareness achieved across difference.» (Debbora Battaglia 1999).

The topic of this paper is the active part the researcher can have in the project he/she is involved in, the advantages and constraints of this active part and the need for a discourse of reflexive awareness to guide this active role. Participant observation in the anthropological tradition as a mainly passive observer has always been problematic. The researcher has never been able to blend into the background (Putnina 2001). Moreover, in the changing environment of globalisation and issues such as HIV/Aids, which transgresses all boundaries, being objective and a passive observer has become a luxury our world cannot afford. Within an anthropology of modernity and addressing the illusions of objectivity, we need to look into new methods of research, which are more empirically challenging (Spencer 1996 p. 379). Research based on active participation in the sense that the researcher takes an active participatory role may be a step in the new direction This sort of research can provide a unique picture, as Putnina experienced when she started to work for the organisation she had done research with previously. She felt that working with the people involved in the research gives you a completely different dimension and point of view (Putnina 2001). Over the past year, I have been involved in a research project that required me to adopt an active role. In the initial stages of the research an agreement was reached with the parties involved (i.e. the project initiators and the NGO) that I would be a researcher as well as a facilitator affiliated to change management. However, I do believe that the active role within research calls for a dynamic discourse of responsibility and a self-reflection and self-awareness of the researcher. At this moment, as the NGO pulls away from the project and I am left alone in the research field it is time for me to reflect how the active role has affected my research (February 2001) and to explore the boundaries of the relationship between researcher and facilitator.

Firstly, it is necessary to describe the integration of the health system in South Africa and discuss the creation of comprehensive services through this integration process. This section will describe the existing services and the implication of the idea of comprehensive services. Secondly the paper outlines the integration process in one of the pilot sites and the workshops and joint planning workshops I was involved in. This part outlines the connected role of the researcher and facilitator. Finally the paper negotiates the active role within the research, paying particular attention to the boundaries between the researcher and the NGO, the pitfalls of this type of research and the problems encountered.

The Integration of the District health system

> *«It won't make any difference, we all have our duties...they can swap us around as much as they like but it will be back to square one. If we take someone from TB to do dressings, we are just left with no one to fill the TB duty. If they think they can improve things without bringing in more money and more staff, they are fantasising.»*
>
> The reaction of one of the nurses in Site A when asked about the integration of the district health system (HST Update 1999).

The integration of the district health system in South Africa is a consequence of the new constitution of 1996, which legislates a transformation and decentralisation of administrative systems. This includes the health services that are currently under provincial authority (i.e. mainly curative services such as hospitals) and services under local authority (i.e. mainly preventative services such as family planning services. The transformation of the health system as stated in the White Paper (1997) opts for the integration of the services now run on provincial and local level. The fragmentation of the health services signifies that two administrative and managerial systems are required. In this system, staffs are subject to different salaries, benefits and working conditions depending on which authority employs them. In addition, patients are able to obtain some services at both facilities but mainly patients cannot have all their health needs attended to at one facility. They are required to travel to a certain facility on a certain day to have their health needs attended to.

During the integration of the district, health system all services will come under one authority and in the future a more comprehensive service will be offered to patients. Over the last five years health officials have been working to bring the health services under one system. The final date for integration in South Africa was set for July 2001 but was recently extended to September 2001. In the Western Cape, a number of sites have been set up to pilot the integration of the district health services. Most of these sites have failed and have abandoned integration. Problems encountered during integration are staff resistance to change and power-struggles between local and provincial government. It is not clear who should take over the new management of the district. Although the process favours local government, they often do not have the capacity or the finance.

Among the lessons learned from the failed projects in the Western Cape and from case studies in the Free State and the Kalahari district in the Northern Cape is the lack of consultation and support for the staff involved (HST Update 1999). In September 1999 the latest pilot site was identified, Site A(1), and it was decided that the emphasis would be on those points. To aid the process of integration, Health Systems Trust (HST) and the Initiative for Sub District Support (ISDS) appointed a facilitator to be involved in change management. The facilitator was to monitor the process and the needs of the staff. The introduction of the Site A community health centres as the next pilot site for integration took place in September/October 1999.

Recently, March 2001, the pilot project in Site A was called off by the NGO when the facilitator left the organisation and a new facilitator was appointed. Supposedly this was an opportune moment for the NGO to evaluate the existing position of the facilitator in the light of the reported achievements in Site A. At the same time the district structure on organisational level in the Western Cape changed with the introduction of the Unicity. The NGO came to the conclusion that the pilot project in the community health centre (CMC) had failed and the new facilitator should be concentrating on a higher level to facilitate the transformation. The official report to go out to the CMC emphasised that the staff had been empowered to negotiate with management. Staffs were encouraged to use the tools and communication structures given to them during the facilitated period of integration in further negotiations.

I became involved in the Site A pilot as a PhD researcher through the Admin. South Africa Project (2) when the pilot was introduced in 1999. The introduction of my involvement was twofold. The project facilitator took both Dr. Jan Froestad (3) and myself to be introduced at a management meeting where we were to announce our intentions and answer any questions. The facilitator stressed the importance of my active role of facilitator within my research. She emphasised that my 'being inside' would give this pilot project an advantage. I would be able to observe the staff's experiences and possible needs and objections. This would give her, as a facilitator, insight in the dynamics of the integration.

With their permission I was then taken to the CMC for a lunch meeting at the CMC, which served as the introduction of the integration process and was at the same time my introduction to the staff at Site A.

Comprehensive services

Site A, the final pilot site chosen, is a mainly coloured township in the Western Cape originating from forced removal under the apartheid regime. In connection with this, the population of Site A faces a high prevalence of TB and respiratory diseases, high unemployment and subsequent psychological illnesses. In the pilot site, the clinic and the day-hospital reside in one building, which the local authority officially owns.

The day-hospital staffs serve as a gateway for the doctor in the facility. Patients come in to the facility with an appointment or a complaint, they are given a number and their folder at reception and then they wait for the nurse outside the room, after depositing their folder in the slot of the door, which is reserved for the day-hospital. The nurse will then proceed to call the patient in, hear their complaint and send them through to the doctor. In the case that the patient has made a previous appointment the nurse will do the necessary screenings, i.e. blood pressure and send the patient on to the doctor. The day-hospital is doctor-driven. The nurses do the screening and other investigations available in the facility, dressings and injections ordered by the doctor but no diagnosing, prescribing or referral.

The service basis of the clinic is different. Patients do not make an appointment for the clinic. Specific services are rendered on specific days and specific hours. However, staff will always make exceptions for people who need their services at other times or are unable to come at the clinic times.

The staffs often know the situation of the patient and will make arrangements accordingly. A patient will come into the clinic and the nursing assistant at reception will receive their cards and dispense the folder among the three available nurses according to their area of speciality; family planning, primary paediatrics, new-baby clinic or TB. However, all the nurses will take each other's patients in case of an overflow. Clinic staffs are able to prescribe and diagnose according to their training.

The first nurse is specialised in DOTS (Directly Observed Treatment Short-course for TB patients) and is able to prescribe and diagnose with the help of a TB doctor attending the clinic once a week. The second nurse is trained in primary paediatrics and she will see most of the children attending the clinic. The third nurse is specialised in family planning. She will take all the women needing their family planning and women with reproductive problems. All the nurses will help out at the new-baby clinic, which is always very busy. The clinic is nurse-driven and highly specialised in their services.

The integration and the creation of a comprehensive service will entail the de-specialisation of services and the transformation of the trust relationship between nurse and client. The impact of the integration on nursing knowledge and practice will not be dealt with in this paper (see Parr, 2000).

The idea of a comprehensive service entails that clients can come into the clinic, fetch their folder and be seen by any nurse, have all their needs seen to and be dispensed medication by that same nurse. This means that all nurses must have a similar knowledge base and no nurse has a specific specialisation. It also implies that the comprehensive health service will be primarily nurse-driven. At this moment, two nurses, one from each facility, have been nominated for the one-year Clinical Nurse Practitioners (CNP) course. A CNP is allowed to prescribe and diagnose under the supervision of a doctor or in absence of a doctor. This arrangement naturally leaves space for interpretation. The need for a CNP was voiced as follows by one of the SPM managers:

> *«What we would like is have a clinical practitioner. So, that Dr. F is not so busy. He could go to Site B and spend some time there. He can give more care to the patients. A clinical practitioner could sit in with the doctor and learn and take over cases.»* (Fieldnotes March 2000).

It seems the intention of the comprehensive services is to make the health centres nurse-driven, freeing up the doctors to do curative services.

Comprehensive services also imply that each nurse should be able to do all the tasks. Currently when one nurse leaves she needs to be replaced by a nurse similarly educated/specialised from another facility. Under the new system, any nurse can replace the other. The notion that nurse practitioners in one profession are interchangeable is a part of the idea behind the suppressed body, practitioners as a uniform body, interchangeable. There is the underlying idea that this will free up nurses to do more outreach. One can leave and another can take over in her place; it does not matter. No nurses from outside have to come in. Training of clinical nurse practitioners, to free up the doctor enforces this. These nurses will be able to do all that the doctor does basically. Two out of five nursing staff members will be trained at Site B. Comparing this to the statistics from 1998 when only 3 nurses in all the SPM clinics were trained (SPM 1998). This enforces the idea behind the creation of comprehensive services that all nursing staff should become CNP's so that the community based clinics become nurse-run. The doctors, then, will only be active in curative services (hospitals). It is expected that nurses will work the preventative services in the community and doctors the curative services in the hospitals. The expectation is that the health services will run more smoothly and the boundaries between nurses and doctors will be clearer. However, it looks as if this will actually lead to vaguer boundaries between nurses and doctors. The new training of nurses will be on a larger scale to get as many CNP's as possible. A CNP has to work under supervision. They are allowed to prescribe and diagnose up to a level but these boundaries shift under different circumstances. The official practice is 'under supervision' of a doctor, which can of course be interpreted in different ways. In rural areas, nurses are even doing small operations.

In addition, a uniform body implies a tightening of protocols and a medicalization of practice. A question that comes up from this is what the role of the nursing assistants will be who have no 'book' training as one nursing assistant put it. She put emphasis on her training inside the hospitals and clinics and the importance of her knowledge by experience. Clients for certain procedures seek her because of this accredited knowledge by experience, which legitimises her practice. With this new system in the health services, the protocols will become stricter and more medicalised, new emphasis will be placed on formal education and her position will have to be re-negotiated.

Comprehensive services and the notion of the suppressed body as the uniform body do not consider the acquirement of accredited knowledge by experience. Accredited and applied knowledge (Friedman 1970) (Lawler 1990) form the basis of legitimisation of practice by other nurses and clients. Neither do comprehensive services acknowledge the existing specialisation. The managing bodies with specific specialisation of practice as they currently exist set up the health services. This specialisation and the set-up of the services as either doctor- or nurse-driven resulted in a specific use of knowledge and provided the staff with a legitimisation of their knowledge and practice for other nurses and for their clients. It also created a distinctive hierarchy in the health services. The proposed new services with their tightening of protocols and medicalization of practice will create a 'professional closure', which is a type of 'Cultural Closure' (Meyer and Geschiere, 1999) (Parr 2000). When confronted with change, nurses react by creating new boundaries and re-affirming existing ones (Parr 2000). The firming of protocols and medicalization of service will fail to acknowledge the body of applied knowledge:

> «The course of applying that (scientific knowledge) to concrete patients in concrete social settings.» (Friedman, 1970).

Lawler (1991) adds to this the three characteristics of accredited knowledge:

> «Becoming an accredited knower of the world [...] requires one to learn ways of seeing, ways of knowing and ways of sharing that knowledge.»

By not acknowledging the acquirement of knowledge by daily experience, one goes beyond the true legitimisation of knowledge that is given by other nurses and clients. These are real considerations when creating a comprehensive service and considering the idea of interchangebility.

The research project: workshops and research

The main objective of the research from the start was, firstly, to explore the construction of knowledge and practice by nurses themselves, patients and the community, doctors and health management. Secondly, to observe the relationships with other nurses in different categories of the hierarchy, patients and the community, doctors and health management which influence nursing knowledge and practice. At the start of the research, I envisioned that this project would give me a multilevel perspective because of my involvement with change management and as a participant observer in the every day setting of the clinic. This was and is a unique opportunity to observe a change process for the beginning to the end. Below I will outline the highlights of the pilot project and my involvement in these.

The pilot project ran adjacent to the research project. The project started in November 1999 with a day-workshop for the staff of Site A at a beautiful location away from their normal environment. The purpose of this meeting was for the staff to share their fears and wishes in connection with the proposed integration. At this stage, it was important to encourage the dialogue between staff members. This workshop, for me, served to become more closely acquainted with the staff. In deliberation with the facilitator, it was decided I should only take up a small role in the workshop. I was to do the playful introduction serving as a 'get to know each other', and work as an assistant and a scribe. Prior to the workshop, I developed a small workbook for staff with several exercises for personal use and an evaluation form. This workshop was the opportunity for me to start observing at the clinic. The reason given to the staff for my presence was quite honestly that I wanted to observe the changes that would take place with the transformation. At the workshop, staff voiced their concerns about salaries and benefits, loss of jobs and the management of the new CMC after integration. The outcome of the workshop included:

- The lack of consensus on what will happen.
- Misinformation from management which induces mistrust.
- The feeling of powerlessness, not having a choice, not knowing what is going to happen.
- The need for visible support.
- The question of availability of sufficient staff and capacity.
- The opportunity for staff to develop with training.

In July and August 2000, the facilitator organised a series of workshops that would facilitate the completion of a functional integration and would lead to full integration. Leading up to this series of workshops were scattered meetings with staff in order to address the issues of collaboration and co-operation. During this time, a steering committee was chosen among the staff from both services with representatives from administration, household and nursing. This committee was to serve as a mechanism for the encouragement of discussion with management. At the same time, this committee was to discuss possible ways forward and notice any problems. Some training took place with staff from both services. I continued my observations and did interviews with the nursing staff to discuss nursing practice across the divide of the two services.

The July/August workshops were to be the last in the series and included the following:

- Identifying current problems and strengths of Site A CHC/clinic and the community.
- Area mapping of Site A.

- Mapping of client service delivery pathways.
- Primary health care and the comprehensive care.
- Client experience and customer care (4).
- Service provision.
- Redesign and changes to health service delivery and structures at Site A.

The aim of this series of workshops was to give staff the opportunity to work through the perceived needs of the community and review the current services on offer. This would make the staff able to evaluate their own service in connection with the community and propose changes in the service.

In September 2000, a meeting took place between staff and management where staff presented their progress and future plans. Staff presented the following:

- Clients have one folder instead of two (formerly clients had a folder for each service).
- The pharmacy would start to order and supply the drugs for both services ('would', because the pharmacist was taken ill soon after the meeting and this has not taken place).
- A new telephone system has been approved connecting both services in one switchboard and under one telephone number. (The telephone arrived in March 2001).
- Two nurses will be attending the Clinical Practitioners Course next year, one from each service. This will enable them to prescribe and diagnose under doctor's supervision. This means that the doctor could be freed up for other tasks and could attend other clinics. (This has happened and both nurses are doing the course).

Both nursing and household stated at this meeting that they would remain the same for the present. Nursing staff stated that if cross training and information were to be made available they would start outreach programs into the community. Household staffs have been against the integration from the beginning. They stated that all three staff members were necessary and could not be asked to do each other's jobs. Unofficially they spoke about the situation where one member would be taken ill and the others would be asked to take over. This would then imply that the third member is not necessary and could be fired.

After this meeting, the site was officially regarded as integrated. However, this entailed only the changes mentioned above. The integration not completed and comprehensive services far from accomplished, the final meeting on 1 March 2001 came as a complete surprise to staff. As stated above the facilitator was leaving and a new facilitator was taking her place. Staffs were told that the ‘ball was now in management’s court’ and over the last year they had been equipped with tools to negotiate with management. This also meant that the proposed client satisfaction survey, proposed by the NGO and completely supported by staff, was now cancelled. However, this survey will take place in the week before this conference. It will take place with my own funds and assistants. This gives me a chance to expand the survey and make more non-structured interviews, which will be more useful. The goals for the survey are the following:

- Who visits the clinic and whom do they see?
- Are clients ‘playing the system’?
- What are the clients’ attitudes towards staff members?

The interviews will allow the interviewers to select clients for in-depth interviews and perhaps find candidates for the proposed life histories.

Summarising, the integration at the CMC started with a workshop in November 1999 in which staff voiced their fears and wishes for the integration. It was then followed by a number of workshops encouraging co-operation and communication and ended with a series of workshops in July 2000 reviewing the needs of the community and the current services. The progress of the integration at Site A was then presented to management in September 2000 and the pilot project finished in March 2001 with the NGO stepping back.

Joint planning for the district

On a higher level, two Joint Planning meetings for the district took place, which involve the pilot project. The first was held in March 2000. This was after the plans for integration had been introduced at Site A. The Joint Planning Workshops are larger meetings with staff from all levels from the whole district and management. The goal of this meeting was to define several priority areas and to appoint task groups, which would work on these areas for the following year. The workshop was organised and facilitated by the NGO. My task in this workshop was to facilitate one of the groups to discuss the possible priority areas. I carefully chose a group that did not include any of the Site A staff. The priority areas chosen at this point were HIV/Aids and TB, Disability and Rehabilitation, Drug Management, Healthy Cities and Violence and Substance Abuse. Management later added two additional priority areas, i.e. Health Information Systems (HIS) which aims to develop statistics, which can be easily collected at the level of the community centre, and Comprehensive Services.

The taskgroup for the development of Comprehensive Services includes the integration of services and the development of services in under-services areas. The goal of this taskgroup is to support integration of services and train Clinical Nurse Practitioners who are able to prescribe and diagnose, officially under supervision of a doctor. This entails that the doctor is free to visit CMC's in under-serviced areas. Areas were there is no doctor.

On 14 March 2001 the second Joint Planning meeting was organised. This time the meeting was organised and facilitated from within, by staff and management. The goal of this meeting was to assess the progress of the taskgroups chosen in the first Joint Planning meeting. Each task group was asked to report on goals and aims, progress over the last year, problems experienced and their future plans. All task groups experienced problems with funding and finding dedicated individuals to drive the process. The task group for Comprehensive Services reported that they had succeeded in identifying staff members for CNP training. These individuals had been chosen from the areas with an under-serviced area close-by like Site A. The outcome of the training and the actual change in practice will take until the end of the year 2001. All CNP's will finish their course and a new nursing practice will be installed.

At this occasion, I was asked to facilitate one of the groups to discuss the reported progress of the task groups and to bring forward possible solutions to their problems. The overall group was smaller and none of the Site staff members were present. Personally, the group discussion served to gain understanding about the issue of community participation. The participants in my group were all from areas where interventions were taking place. They all agreed that the problem with community participation was one of ignorant organising. Meetings are organised by people from outside the community, often in places where it is not safe to travel to at night. Additionally members of the community often do not have the means to travel to the location. Moreover, members of the community are expected to participate on Saturdays, usually reserved for family activities (Joint Planning Notes March 2001). Another consideration is that participating in a clean up or an education programme is to admit the community has major problems, which it cannot solve without the help from outsiders (Fieldnotes May 2001).

To summarise, both Joint Planning Workshops were concerned with the larger district development. The first workshop served to identify priority areas and the second assessed the progress of the assigned taskgroups in these priority areas. My task in these workshops was one of scribe, observer and facilitator. In these meetings, I did not engage with the staff members of Site A. however; I did ask the staff about their experiences after the meeting.

Active participation

The active role of researcher brings up the question of boundaries. The researcher is both observer and active participant. The question of boundary pertains to the extent of the participation in the context of observation. The researcher has to actively engage with this question in the sense that each action needs to be seen with its possible consequences. It is of vital importance to contemplate whether the research or those involved are compromised by any of the decisions made by the researcher. In the following section, I will investigate the negotiation of these boundaries within the context of my experience and fieldwork. This includes legitimisation of the research, identity construction, and the pitfalls and the maintenance of these boundaries in the changing environment. A connected issue is the written material issued during the period of integration and research. This includes my reports and conference papers and the reports issued by the various institutions involved.

First, there is the relationship with the NGO that acted, to a certain extent, as the legitimating factor for the research. Although the senate reviewing my research proposal wouldn't agree, the active role was seen as an advantage and served as a legitimating factor for my research. Both the introduction to management and the CMC staff included this active role. The part of the co-facilitator was seen as a potentially positive position.

The relationship with the NGO was mostly limited to interaction with the facilitator. My main concern here was not to be involved too much and not to be identified with them. The interaction with the facilitator included mainly workshop preparation, as discussed below.

Workshops were planned by the facilitator and then discussed with me. We would discuss the goal of the workshop compared to the current situation at the CMC. I would brief her on the situation at the CMC pointing out the problem areas. This information the facilitator could then use to talk about the real issues and 'workshop' through these. Obviously, this is a very sensitive issue and a precarious position to be in as a researcher. This type of interaction brings up issues of confidentiality and the betrayal of trust towards the staff. However, the facilitator proved to be very sensitive. She would work with the information in such a way that staff would tell her about the issues themselves. Moreover, I would only give her information pertaining the integration. No personal information about staff was ever imparted to the facilitator.

At each meeting, my involvement in the workshop was carefully discussed. The schedule of the workshop would be reviewed and the possible result for the fieldwork and my position discussed. The activities selected for me would be mainly introductory exercises and scribe. These activities were designed to give me a legitimate part in the workshops and yet maintain my position.

A more problematic side of the co-operation with the facilitator was inside knowledge. One of the major benefits of active participation in this project was the multileveled access. I was often aware of thoughts, policies and actions from one of the three levels i.e. management, the NGO and the CMC, that was not known to any of the other levels. Some of these could have a potentially negative outcome for staff. One such example was that staff was ensured at the start of the facilitated integration process that no jobs would be lost. Later on in the project, it became clear that this was by no means certain. Within the creation of comprehensive services, the position of staff with accredited knowledge by experience could be potentially precarious. At this moment in the integration, no jobs have been lost but then nothing has really changed at the CMC. However, one of the nursing assistants has started her nursing course to become, as she calls it, ‘a book nurse’. She started fighting for her right to do the course shortly after the start of the guided integration process. Another example was that I was aware of the conclusion of the pilot days before the meeting. At the meeting, itself it was quite clear that none of the staff had anticipated this. Moreover, I was aware of the discrepancy in the unofficial reason for the stop of the pilot and the reported reason presented to staff. (See above p.3 The Integration of the District Health System). This is probably the most challenging part of active participation. As the researcher, you are often party to information from more than one level of the organisation/community.

My research at the CMC started with an introductory period constructing my identity in the field. The path taken to construct this identity was to spend a day with each member of staff to observe their activities. Gaining trust takes time and I had to prove to each of them that I would not talk to others about what they had said to me in private. Many staff members had entrusted me with professional issues and personal problems. Staff needed time to realise that their thoughts and worries were never disclosed to another staff member. One example of this is that I once found out why a member of staff had taken leave without consent. I overheard her on the telephone without her realising. Although I had told her many times that I understood Afrikaans perfectly, she would not believe me. Later that day the sister-in-charge asked me if I knew anything about her taking leave. In front of all her friends, I stated that I had no idea. These small incidents help to establish a trusting relationship. This staff member is now the person who will disclose recent problems and staff clashes on my arrival at the CMC. Moreover, staff members have come to realise that I will not give my opinion concerning the integration. I merely listen to their opinion. Thus, it has also become clear to staff that I do not take sides. It has become clear to staff that I am also not with the NGO or with management. I am merely concerned how the process of integration impacts on nursing knowledge and practice.

The pitfalls of active participation in research can include being used by staff members for their hidden agendas. One incident at Site A occurred at a staff meeting. One of the staff members telephoned me and asked me to chair. I only realised while chairing the meeting that this staff member had a personal reason for asking me to chair this particular meeting. It had come to her attention that the other members of staff were going to confront her. She thought that if I were to chair the meeting they would not do this. She was correct and during the meeting everyone stayed very calm and once again focussed on issues, they did not have any power over e.g. the telephone system and training. This obviously is a case in which the 'active participant' part of my research was used against me. However, pitfalls often serve to uncover the hidden dynamics in the organisation or community involved.

The final issue to consider is the papers and reports. Firstly, there are the papers I have written for conferences. It is virtually impossible to disguise where the research is taking place. Site A is the only pilot site in the Western Cape. This pertains to the identities of the informants described in the papers. Fortunately, most papers have been written for conferences abroad where neither the project nor the staff is known. Other reports have been written for colleagues within the research project who understand the problem of identities. Furthermore, the informants' identities are disguised in the papers. If possible the informant's gender is changed or the informant is placed in a different setting. Official reports to the NGO and management have always been without particular incidents between particular individuals. In these official reports, the problems are generalised without details of specific incidents to protect the individuals involved.

Currently, with the ending of the pilot project, the role of the facilitator comes to an end. The legitimisation of the facilitator falls away and I am left to legitimate my research in a different way. Obviously, it makes the research less complicated but the boundaries have to be re-negotiated with the staff. Fortunately, the NGO never managed to organise the client satisfaction survey. However, staff feels this survey is an integral part in improving the services. It has given me a chance to legitimate my research. More importantly, it serves to reciprocate. The survey will give the chance to gain entrance into the community and identify essential informants for the community research.

Notes

(1) Site A is a pseudonym.

(2) The Admin. South Africa Project is funded by NUFU in Norway and is a collaborative effort between the University of Bergen and the University of the Western Cape. This particular study falls under the Health Section of the project.

(3) Dr. Jan Froestad is a visiting researcher from the University of Bergen. His involvement is on a higher level in the structure of the Health System. His research, that of Dr Diana Gibson and my own are linked within the health section of the Admin South Africa Project.

(4) This includes a client satisfaction survey, which will have taken place in the week before this conference. Originally it was to be in co-operation with the NGO, the clinic staff and UWC.

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 87-99

From accident to diagnosis.

Cultural response to the risk of osteoporosis

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Introduction

New biomedical knowledge is produced and new disease categories are created. Biomedicine and especially epidemiology focus at the determination of health risks and risk factors and how to diminish these health risks. This fact changes the medical discourse and influences lay people's perception of health and health risks. The aim of this article is to discuss the changing ideas of bone fractures as a natural accident to the invisible risk of osteoporosis (brittle bones). My concern is to examine how women's body experience changes due to new biomedical knowledge and in particular how they articulate this change in the context of a new disease, osteoporosis. How women comprehend and have experiences with bone fractures, osteoporosis and the risk of bone fractures, provides knowledge of society and cultural values. A cultural analysis of perception of risk and osteoporosis contributes to a more profound anthropological understanding of the human condition in a changing world. The present study explores the narratives of elderly women and their perceptions of bone fractures and osteoporosis.

Osteoporosis is defined by biomedicine as the loss of bone mass or the phenomenon of bones becoming brittle. It is known mainly as a female condition (see Wingerden 1996, Lock 1993). The World Health Organisation WHO defined osteoporosis as a disease in 1991 and the biomedical discourse related to the condition has changed a lot over the last 10 years. Osteoporosis leads to increased bone fragility and a consequent increase in risk of fracture. Mostly it occurs among elderly people. In practice, it means that people will be diagnosed as osteoporotic using a bone scan, when their bone masses are lower than the young adult mean. Nearly a quarter of white women aged 60-69 is in this group with an increased risk of fracture (WHO 1994). Osteoporosis will remain invisible in the body until a fracture occurs. Because of hospitalisation expenses, the most important osteoporosis-related fractures are those of the hip. Secondary to this is the fractures of the backbone, which also have great significance (Scheper-Hughes & Lock 1987).

Two or three factors have contributed to the attention on the idea of preventing bone fractures (especially of the hip). The first is the growing attention that is being given to health risks and prevention, based here on the predicted probability of bone fractures. The second is the development of medical technology and the growth of pharmaceutical companies with the possibility of scanning for osteoporosis and treating the condition. In this connection, Lock argues about a triangulation of interest, which also includes the medical profession (Lock 1993). Another important issue is that the growing elderly population, especially the disabled elderly, increases the workload involved in state care for the elderly in the Western countries.

Previously, a hip fracture was mostly seen as a natural accident. Today, along with many other health risks, it has changed from an unpredictable misfortune into a preventable misfortune as argued by Judith Green in her book *Risk and misfortune* (1997). She points out that an accident should be an unmotivated event that is unpredictable and unique. The occurrence of a particular accident cannot be foreseen. In this context, she argues that accidents today have almost disappeared (Green 1997). This applies to hip fractures, when it is now possible to find people with osteoporosis and to predict the event, which might happen 10-30 years in the future.

Information about osteoporosis is now freely available. The Health System defines osteoporosis as a disease that can be found and treated with medicine. Guidelines about how to handle osteoporosis in the Health System are now available in Denmark and many other countries. These describe the importance of prevention by changing lifestyle and finding women with high risk of osteoporosis and offering them treatment. In the medical literature, articles about osteoporosis have increased from 1258 (between 1966 and 1970) to 5116 (between 1996 and 1999) and articles about risk and osteoporosis have increased from zero to 1604 in the last 4 years (Skolbekken, 2000). The Press and Osteoporosis patients' associations tell that we face a new and widespread disease. The Osteoporosis patients' association tells that we have a new serious national scourge, which primarily hits women and almost one third of women will get the disease. The aim of the association is to fight against this anonymous disease, which is characterised by the crumbling of the skeleton, pain and the fact that it causes disability. Lay people also know the term osteoporosis.

This changing discourse in medicine and the creation of the new disease category of osteoporosis both as a visible as well as an invisible disease will have impact on women's comprehension and experience of their body.

Study of women's' experiences with osteoporosis

The present study was conducted in relation to a population study in the County of Copenhagen, Denmark. The aim of the study is to explore women's experiences and perceptions of osteoporosis and bone fractures, their perception of health, health risks and prevention. The women in the study were born in 1936 and participated in the population study based on a questionnaire and a health examination at a Danish hospital, but without a bone scan (for osteoporosis). In the questionnaire, the women were asked whether they were prepared to participate in small focus groups or in-depth interviews to be held at a later date to provide qualitative information about their experiences and perception of osteoporosis. Four focus group discussions were conducted with 22 women (group size raged from 4-6 participants); aged 60 to 61 selected from the questionnaire. Assignment to groups was organised according to criteria based on the women's responses in the survey to questions about osteoporosis. The selection criteria for the focus groups were that the women had a knowledge of osteoporosis, had experiences with osteoporosis, had had a bone scan, thought that they themselves were at risk of osteoporosis or had experience of bone fractures.

The location of the focus group discussion was in a meeting room at the Centre of the Population Study, a building close to the hospital in Glostrup. Tea, coffee and bread were served at the meeting, which lasted between 2 to 2½ hours. The researcher had the role as moderator for all 4 focus groups. The researcher was presented as a researcher related to the population study, an anthropologist, a social scientist and GP. The idea with the focus group, to get knowledge about women's comprehension of and experiences with osteoporosis and bone fractures, was explained several times. The moderator kept a low profile, trying to let the women discuss the subject without disruption, but still tried to get everyone to participate in the discussion. In the first two focus groups, a co-referent that is also an anthropologist participated. Field notes (including observations about the participants and their setting) were recorded after the interviews.

Each discussion was audiotaped and transcribed in full (verbatim). The tapes were listened to and the transcripts read repeatedly. Data from the focus group discussions were coded to explore potential themes related to content and concepts.

After the focus group discussions 18 women diagnosed as osteoporotic or at risk of having osteoporosis (defined by them) were followed over 3 years and ethnographic interviews were conducted, mostly in their homes. In the interviews the women often told about their experiences in narratives (Polkinhorne 1993: 6), a story, where events and actions are drawn together into an organised whole by means of a plot (Ibid. 7, Good 1994:144). A plot is a type of conceptual scheme by which a contextual meaning of individual events can be displayed (Polkinhorne 1993: 7). My analyses of the narratives focus on the phenomenon of osteoporosis and to see this in context, not only in relation to what will happen now and here, but also in relation to what has happened before, and what will happen in the future. As well as the focus group discussions and the ethnographic interview, I participated in meetings with the patients' association and collected material concerning osteoporosis from newspapers and magazines to supply my data. The study is still ongoing and the analyses of the interviews have not been finished. In this paper, I have used 2 women's stories of osteoporosis to illustrate how the diagnosis of osteoporosis has affected their lives. In particular, I focus on how they comprehend bone fractures and the risk of having osteoporosis. To comprehend these stories in the context of my study I will include material both from the focus groups and the interviews.

Bone fractures as a natural accident

Most of the women in the study who had not been diagnosed as osteoporotic talked about fractures as understandable. Fractures were reported as natural accidents related to a fall. For some women this perception will change when they get a diagnosis of osteoporosis.

When the focus groups discussed bone fractures in general, the talk concentrated on the accident or misfortune of falling and getting a fracture.

One woman explains:

> *«To fall at the age of 70 to 90, you accept that something will happen. You don't break the fall the same way that a younger person does. You just fall. When I broke my wrist, that was also from falling, but I managed to break the fall and then I broke my wrist.»*

Another woman explained the accident as a result of being clumsy and mistaken. When she tried to break the fall, she was really unlucky. Bone fractures were not seen as a disease, but as a question of an accident and the way, you fall.

The fall and the fracture are seen as an unmotivated and unpredictable event. It just happened. Only you must accept that you have a greater probability of falling and getting a fracture when you grow older.

One woman commented that she did not think that it was natural to break bones. To understand her we must look at her perception in the context of her own experience. She commented first that she has a friend whose back collapsed one day when she was getting off her bike, and to day she is in a lot of pain. But the woman herself has osteoporosis and lives with the feeling that one day her bones will suddenly collapse. Her perception of bone fractures is based on her experience with her friend and her image of osteoporosis, which I will return to later in the paper. First, I will introduce the stories of Linda and Rose.

Linda's story and how she embodied the experience of a bone scanning

Linda is 61, married and works in her husband's silverware shop. She lives in a big house in the countryside. She has always been enthusiastic about sailing and she presents herself as a nature lover.

She said that, three years previously, she had learned the fact – by chance – that she had calcium loss. She got the idea of having a bone scanning from another women, who had a normal bone scanning, so she expected the same result.

She goes on to say:

> *«I was scanned. Afterwards, the doctor showed me on a small screen, what was wrong and said that normally I should be up there, but if we went backwards and saw all the way down here I was there and in really great danger. I must walk carefully on the way home or something might happen». «And you must go to your own doctor tomorrow to start treatment».*

Telling her story Linda reflected on how she comprehended her situation and the information given. First, she had never experienced her body being in danger. Linda had not expected to have osteoporosis, even though she had had bone fractures – of the ribs and also of the shoulder when she had to push the car and she fell right onto her shoulder. Before the bone scanning, she could understand the bone fractures being the result of a fall – a natural accident, an unpredictable misfortune, but now it is different.

Linda explained her further reflections:

> *«You feel that it is OK that you break the bones when you fall, when you don't know the real background»*. (She now knows that she has osteoporosis).

She continues:

> *«Besides the fractures I have mentioned, I have never broken anything - and therefore I was very much astounded that I was in such great danger as the doctor told me»*.

Telling her experiences Linda turned back several times to her perception of the actual danger and her earlier fractures. Through her reflections of her experiences, she came to a new recognition about her situation, before she had the experience of her physical body being hit by misfortunes. In her story, she explained her primary astonishment over the danger, but she accepted it. At a bone scanning two years later, she asked the doctor if she could stop treatment when she felt it was better. She was told that the medication was absolutely necessary also in the future. She had no possibility of checking up on the doctor's statement.

In the beginning, Linda did not embody the risk of osteoporosis but now, she continues:

> *«Well then, I really must say that since I got osteoporosis, I'm very very cautious. I'm much more cautious than I've ever been. When I am walking now, for example in such bad weather, I walk very carefully, I must admit. I've never done that before... I've never been thinking... I guess I've hurried too much, you see... but luckily I've been spared... so I dare not do that any longer»*.

Linda's comprehension of her body has changed over the last three years. The risk Linda experiences is not a statistical risk in numbers, but the meaning of risk as an unacceptable danger (Douglas 1992). Even if Linda doesn't feel sick she now has a lived body experience of an "at-risk" health status, where the risk of bone fractures in some way is predictable and an always present danger in the body. Linda explained her fear of being disabled, but she is also afraid that osteoporosis will change her appearance. She has to be careful to prevent the risk of future sickness by taking her medicine and walking carefully.

I will now turn to the story of Rose. Her story is similar in the way the diagnosis of osteoporosis changes her comprehension of bone fractures, but she is even more affected by the risk that having osteoporosis involves.

Rose's story of uncertainty

Rose is 62, a married housewife living in a flat. This story is from my first meeting with Rose in 1998 in an office at the Centre of the Population Study. She didn't want me to visit her in her home the first time we met.

She starts:

> *«It was in 1991 when I broke my arm. It was examined and I was told that my calcium was varying. So to stop that I was given hormones. Then in 1996 I broke this shoulder. I didn't think of anything before, I was only told what to do about it, but after breaking this, I started being scared of falling again. I have never been scared of anything. I have always walked with my head held high. You see, when I was on my way over here today I couldn't decide if I should walk, should I bike, or should I drive? Then I said to my self, I don't want to become crippled. I don't know what is wrong, now I walk. There are some places where I have to walk my bike, which I have never done before. Now I walk my bike. My husband is also nervous about what might happen next time I fall, what would I break then. That is what has entered our lives that wasn't there before.»*

I will focus on how Rose's story shows how her present activity is related not only to earlier experiences, but also to her present life situation and how she experiences herself in this. The content of the story contains descriptions of earlier events together with experiences from the same day. At the same time elements in her story should tell me what kind of person Rose is.

It seemed not to affect Rose that much when she broke her arm and had the examination for osteoporosis. She refers to the result of the examination and how she comprehended osteoporosis to be the result of the calcium leaving the bones quickly and varying. She expected that the hormones could prevent the problem. But after the second fracture, an experience of uncertainty has entered her life and she cannot trust hormones to protect her.

What has entered Rose's life is a lived experience of the possibility of falling, breaking her bones and being crippled. She tells us that before the bone scan she had fractured her ankle, but that she didn't think of osteoporosis at that time. After the fracture she is retrained, it was painful, but only for a time. The broken shoulder was much worse. Rose talks about her fear to become an invalid. She doesn't like to feel like an invalid because she has osteoporosis, but she is really afraid of being an invalid and depending on others. The family wouldn't be able to get by. Rose keeps trying to make me understand her and what sort of person she is. She tells me how she has taken care of her disabled son for many years and how she saw her father as an invalid; it was discreditable to him. Rose explained that she has always been the central person in the family. She is the person who takes care of both the practical works in the house as well as any emotional problems in the family. Telling her story she creates connection and meaning and puts her perception of osteoporosis into this context. Rose sees herself as an individual caught by the disease of osteoporosis. She experiences it as a chronic sickness; because of the way she lives her life in fear of a new fracture.

The danger and uncertainty of osteoporosis

The social anthropologist Douglas defined risk as the probability that a definite event, good or bad, will occur, combined with the size of loss and gain that it will bring. Risk is not only the probability of an event, but also the probable size of its result, and the value that is attached to the outcome (Douglas 1992: 31). Epidemiology works with risk as an objective probability. When risk is used in clinical medicine, it contains the value of normality in health as the optimal state of health and the acceptance of prevention in general as a good thing, also when it concerns prevention and treatment of such health risks as osteoporosis.

For the sociologist Ulric Beck, the public and the women in my study, the word risk is used as danger (Beck 1992, Douglas 1992: 39). The risk of osteoporosis is many times perceived as an unacceptable danger, which should be treated with hormones. Ulric Beck argues that the extent to which people are endangered by risk is to some extent dependent on knowledge, a knowledge which frequently the victims themselves do not have (Beck 1992:55). For Linda, the process of accepting danger – the threat to her health – was explained in relation to her acceptance of the biomedical knowledge.

The danger of osteoporosis includes the concept of uncertainty; when and where will the next unexpected danger of falling happen and what will it do to them? Linda and Rose explained that they are afraid of walking in bad weather and riding a bike. Risk as described by Douglas can be measurable while uncertainty is immeasurable. To control uncertainty some of the women act as if the risk is high.

As in the stories of Linda and Rose, the study illustrates how many women feel a kind of uncertainty about osteoporosis. Linda's interpretation of the risk communication is that she has a disease in addition to her previously experienced, but not frightening, fractures. The threat concerns a phenomenon whose consequences she is familiar with, but when the risk is part of an unknown system such as osteoporosis, then the risk seems greater (Slovic 1987). Some of the women in my study relate other bodily symptoms to osteoporosis too, as one woman says:

> *«I am a little scared of one day looking like that, I have it everywhere else but my back, also my arms and knees hurt. I am afraid of my hips, because they hurt. Then I think that they are even more porous, but I don't know that and I would like to know».*

Osteoporosis is invisible until you get a fracture. This uncertainty causes other (many different) bodily symptoms to be associated with osteoporosis. Uncertainty, then, concerns both the interpretation of risk as immeasurable and osteoporosis as part of an unknown system.

The diagnosis of risk or belonging to a risk group of osteoporosis

Many women in the study perceive themselves as belonging to a group of risk.

One woman explains:

> *«I belong to the group of risk, I have had the menopause since I was 36. I was a smoker and I was thin, so he would very strongly recommend that I took hormones».*

In her perception of her risk of osteoporosis, she includes her menopause and hormone production, her lifestyle and her body weight. Many of the women in the study have the idea that they lack hormones and hormones are perceived as one of the treatments for osteoporosis. Another woman says:

> *«I realised that I lacked these hormones and when that happens you cannot absorb calcium».*

The women's perception of the risk of osteoporosis concentrates on osteoporosis as a disease related to women and hormones and a disease related to lifestyle, which has a profound moral impact on their lives. They accept that they live with an invisible disease or risk only because they have some of the defined risk factors (1) as mentioned here by the women. A woman says:

> *«I haven't drunk milk is synonymous with I will not get away with it».*

The quotation illustrates how the women's comprehension of belonging to a risk group of a new disease category such as osteoporosis affects them not in the meaning of risk as probability, but rather that they expect to have the disease in the future.

Images of osteoporosis

To comprehend Linda and Rose's stories in the context of my study I will now include some interview material about how the women express their understanding and image of osteoporosis. The image of the body should be understood as an individual's attitudes, feelings and fantasies about her body (Helman 1995). The image of osteoporosis should then be understood as an individual's attitudes, feelings and fantasies of her body having osteoporosis.

The women both speak about the image of osteoporosis as a frightening social sign of ageing but also how they perceive osteoporosis to look in the body.

In the words of two participants:

> *«The scary part about osteoporosis is those elderly people who actually fall forward».*
> *«My mother and my aunt fell totally apart and were completely pulverised, the new hips crumbled and their backs became totally hunched».*

Embodying a silent or invisible condition gives rise to many different performances of sickness and fear (Frankenberg 1993). This is based on the social and cultural meanings associated with being a woman in a Western (Danish) society and with how they perceive health and health risks (threats to health) in this context (Scheper-Hughes & Lock 1987, Monks & Frankenberg 1995, Douglas 1992, Kleinman 1988). Osteoporosis cannot be sensed and controlled by the individual, as long as it remains a symptomless invisible risk factor. The anthropologist Sachs argued that when the invisible in the body is made visible, many feelings and experiences arise in the body and a process is started in an attempt to make the experience meaningful (Sachs 1995). The uncertainty of osteoporosis is also a question of the fear of ageing and the cultural meanings associated to ageing in the Western Society (Bytheway & Johnson 1998).

Many of the women use the image of sponges, where osteoporosis is explained as the bones becoming porous and looking like sponges. Similar to this is the metaphor of bone flour and the image that the bones start to pulverise.

One women says:

> *«But really it is when one starts having osteoporosis it is like a ghost. I'm not so afraid of a fracture in a rib because it grows so easily together, but of the structure of a bone itself and then the flow of liquid».*

The skeleton is described as the foundation of a house and if it doesn't function, then nothing is okay. As one women describes earlier in this paper she expects that one day her bones will collapse. The women's images of osteoporosis contain some very strong metaphors, which illuminate not only their understanding of the phenomenon of osteoporosis, but also what osteoporosis means to them in their everyday lives.

Netteton & Watson argue that the image we hold of our bodies will, to a greater or lesser extent, impact upon how we experience our bodies in everyday life (see Nettleton & Watson 1998). The body image is shaped not just by what we perceive our body to be like, but what we see and how we interpret our vision of our body, mediated by our social and cultural context. The act of perception is a socially constructed process (ibid.). This involves both the experience of bodily changes and their social perception. Many of the women in the study argue that they have never thought of osteoporosis like this before. Earlier, when they had talked about how elderly people looked, they said that they had worn themselves out (a bent old lady is now one with osteoporosis). Now when the women talk about osteoporosis, they reinterpret the past from their present knowledge, saying that they now think that their mothers might have had osteoporosis and from this construct a new promise of sickness and ageing.

Conclusion

Biomedicine produces definitions of health risk based on risk as a statistical concept that is knowledge of epidemiology on a group level (Reventlow et al. 2001). The medical profession can predict the probability of fractures, but for the women the important thing is that they live with the uncertainty of a danger in the body, meaning that they suddenly might become crippled and old. They don't know when or if it might happen. As one of them says:

> *«You can have something without knowing it, something that doesn't hit you until you get older».*

This article demonstrates how the new disease of osteoporosis, which can be treated with hormones, creates fantasy both as a disease with symptoms but also as an invisible disease that gives a feeling of insecurity and fright. The uncertainty of osteoporosis is also a question of the fear of ageing and the cultural meanings associated to ageing in Western society (Bytheway & Johnson 1998). It shows how women imagine the phenomenon of osteoporosis in its most distinct and advanced cases as the image of a bent old lady and crumbling bones. Women's images of osteoporosis shed light not only on their understanding of the phenomenon of osteoporosis, but also what osteoporosis means to them in their everyday lives.

Decades ago, a bone fracture would have been regarded as a natural part of old age. Bone fractures as natural accidents still exist among women not affected by a personal experience of osteoporosis, but experience of osteoporosis has changed all this. Today, women describe osteoporosis as a ghost or a phantom in the body and the bone structure of the skeleton as a house, with the scary metaphor of crumbling bones and a bent old lady. Still, to women, the risk of osteoporosis remains invisible. Osteoporosis cannot be sensed or controlled by the individual, as long as it remains an invisible risk factor. The stories of the women show how new medical knowledge about osteoporosis influences women's' bodily experiences. When women have a bone scan the danger of osteoporosis becomes part of their present life, and at the same time they reconstruct their past in their narratives and construct an anticipation of the future. With the focus on prevention, the health system has created a being in the present based on the prevention of future sickness as a full-time present danger.

Osteoporosis as a biomedical diagnosis has stimulated a cultural response in society. The women in the present study tell of their experience in the context of their cultural understanding about health, illness and self, resulting in different behaviour and sickness performances. Women's accounts of bodily experiences should then be understood as the ground of culture and self (Csordas 1990). The experience of osteoporosis must be viewed not just as a physical body experience in a biological sense but as a lived embodied experience, that is, which acknowledges the complexity of human embodiment and accounts for the way we experience a particular phenomenon.

Notes

(1) In epidemiology, risk is defined as a statistical probability that an undesirable event – disease or death – may strike people. Now it is possible to determine the probability of disease associated with many factors – risk factors. The term 'risk factor' refers to a characteristic of the individual, or in relation to the individual, that is statistically associated with an increased probability that a certain undesirable state of health will appear (Reventlow *et al*. 2001).

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 101-122

Rituals of health information in South Peninsula district, Cape Town, South Africa

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Introduction

The creation of ritual has contributed to increased understanding and analysis, as well as more effective utilisation of data collected as part of a health information system (HIS) in municipal facilities of the South Peninsula District of Cape Town, South Africa. In this process, cultural brokerage has played an important role in establishing greater acceptance by staff of the new dispensation.

> *«We do it, the site HIS [health information systems] presentations regularly and also the TB [tuberculosis] quarterlies ...now the RMR [routine monthly report], the way we present and analyse it has become very similar in its practice. Like the TB meetings, every three months we go in, sit down, get up one after the other, take the zero tables and check them, check them with Dr B, enter the data you know. Then it is show time, putting the stats, graphs, and the pie charts on. Dr B comes, people stop talking, we give attention, each one goes to the front to do their thing... it has a pattern, it is not so chaotic anymore, even when we do not really understand all the time, we all go through the motions... It represents what is happening out there, our services at base line, our clients, the problems, how we relate to other facilities... but mostly we are getting a handle on it.» (Professional Nurse).*
>
> *«Dr B made the difference, she keeps on going back and forth between the stats, the RMR [routine monthly report] and what it actually means on the ground, in the clinic, how it reflects what we do here. She understands the RMR, she knows what happens in the clinics as well, and she picks it up all the time, relating it. It is almost like show and tell, but with a lot of meaning behind it.»* (Clinic Manager).

The above narratives by professional nurse practitioners capture two important issues that help make the implementation of a HIS in municipal health care facilities in the South Peninsula district (1) relatively more successful than that of the provincial administration of the Western Cape. The first involves a process of ritualising the presentation of a HIS through the production and presentation of the routine monthly reports (RMR) and its feedback sessions as analytical bureaucratic and pedagogical performances.

The second relates to mediation by a specific person who continuously brokers between the everyday working world of health care provision and the technological health information system (HIS). This is relevant when the relatively successful implementation of the health information system and use of the RMR in municipal facilities in South Peninsula are compared with the Western Cape Provincial facilities, where it was not utilised in the same way.

These issues can perhaps best be understood against the background of ongoing change and transformation in the South African health care system since 1994. It was an effort to provide more uniform, equitable and responsive health services (Heywood & Froestad 2000), that are driven by Primary Health Care considerations and are open to all sectors of society. The Health Information Systems Pilot Project (HISPP) is aimed at developing a district-based Health Information System in the Western Cape and is guided by a Primary Health Care approach (Healthlink 1998). However, the status and success of this enterprise is filled with contradictions and a confusion of categories. For example, discourses on health statistics in South Africa portray pre-1994 data sets as racially segregated, biased, untrustworthy, fragmented, discredited, unrepresentative of 'reality' and open to political manipulation. For effective delivery of health care service there needs to be order, cohesion and pattern. Consequently, setting up and developing a health information system (HIS) for the various districts in the nine provinces of South Africa was viewed as a way to make available:

> «A constant supply of reliable information to enable it [the health service] to plan, implement and evaluate tasks that are needed to run the district.» (Ramduny *et al.* 1998: 4).

A comprehensive health information system (HIS) that originates at local facility level and subsequently feeds into provincial and national information systems were seen as an essential part of such a process. A general aim of the development of HIS was to utilise the collected data to enhance strategic planning and policy formation, monitor health care delivery, evaluate specific health programmes and assess the progress of district health plans as well as provincial and national health strategies (ANC 1994: 81).

Health services per se are supposedly becoming more business-oriented and health information can be vital in running a responsive service while helping to control costs. The implementation of a health information system involves the acquisition of certain technologies and technological skills, but it also requires insight into and impacts upon the cultural and political issues that determine the success or failure of such a system (see Campbell *et al.* 1996; Hackey & McBride 1995).

I focus on three interrelated issues that can help give insight into the above requirements. The first was reflected in documents and training concerned with the implementation of the Health Information System (HIS) and related to an emphasis on the 'creation' of an 'information culture' and of people 'taking ownership'. Although the necessity of such a progression was stressed, in reality, the process was very complex and uneven and it needed to be sustained over time – well beyond its implementation, and the subsequent training workshops for staff working in health facilities.

A second aim was to show how the ordinary actions of engaging with the HIS, through the presentation of the RMR and feedback sessions, could gradually transform mundane activities into ritualised performances. Where this occurred, clinic staff seemed to be more inclined to display a sense of co-ownership. The third focus was on the brokering role of a person who guided and mediated the enactment of the realisation of the aims and objectives of primary health care through quantifiable 'health facts' or statistics as a science of public health and a tool to chart and display its progress. The above-mentioned Dr. B, the health information systems co-ordinator, adopted this brokering role for South Peninsula Municipality.

The research for this paper was conducted during 2000 and it involved several months of observation of meetings at which health information and the routine monthly reports were presented. Towards the end of the year, interviews were conducted at six clinics and two Community Health Centres (CHC) in South Peninsula. Informed consent was obtained and the identity of participants has been concealed.

Implementing the District health information system

Relating information systems and social practice

In the District Information System Model, the district data base is situated at a district information centre that links up the various role players or constituencies, and collects, collates and analyses data. However, such a system cannot simply be acquired and implemented without the important component of human agency. Successful implementation involves a complex and long-term process of socialisation of role players into an 'information culture' through a process of learning and practice, as well as organisational and managerial change. Only if everything is in place will it be possible for the people at local level to take 'ownership' (see Heywood & Magaqa 1998; Health link 1998).

Although information systems are constructed as somehow rational and neutral, this is not necessarily correct. Behind the concern with generating a body of data through a health information system lies a particular Information Science epistemology, which assumes that knowledge and the information that illuminates it are somehow objective, absolute, based on extensive, empirically generated, verifiable evidence and facts, generated through certain prescribed procedures, logically analysed and which can be tested and replicated in return (Gibson 2000: 8; Lett 1997:3).

However, the HIS is embedded in the social and political context of which it is part and cannot be separated from practices and relations in the workplace. The information required involves different layers not only of data, but also of activities. The data is collected at facility level. Thus involves the health workers in particular facilities and administrative staff at each site, after which the raw data has to be collated and processed for the RMR (see Attachment 1) so that it can be analysed and produced in some or other format such as graphs, reports etc. Finally, the data has to be utilised in some way. All these layers involve the active participation of a variety of people at different levels (Hackey & McBride 1995; Braa & Hedberg n.d.).

Since many categories of people were involved in the process of setting up, updating and utilising health information systems, it was necessary to consider how the different levels moved between their routine working-world and a health information system, what the potential areas of conflict and misunderstanding were, and how effectively the system implemented. What transpired was a process in which health caregivers learned to cope with the everyday contingencies of service delivery, as messy and unpredictable as this was made by having to deal with a myriad of minor emergencies. This had to be 'translated' into and presented as the apparently rational, yet very restrictive descriptions captured in HIS, which were supposed to be representative of the services they delivered.

Training staff in an Information System

Selected staff members were instructed by a health information systems pilot project (HISPP) trainer in South Peninsula, Ms A. She familiarised the staff in the use of the computers, the relevant programmes and the technicalities of setting up a data system like the RMR. She taught them the precise definitions for each data field and how the required indicators should be calculated, how to use range and validity checks, and how to import and export data. She also showed them how to use the computer with confidence and familiarity, how to deal with incompatible computer programmes and problems, and how to use e-mail. Staff was cautioned by Ms A not to change minimum and maximum values in the programme, and exhorted to acquire skills needed to enter data, etc. Ms A stressed the importance of the sustainability of the whole process that staff should "take ownership" and "train their own" (field notes: 17/3/2000). It was clear from the input that what was envisaged was a process of diffusion of the skills, knowledge, attitudes and practices related to the HIS. Despite her ongoing emphasis at HISPP meetings on buzzwords such as "creating an information culture" (field notes: 17/3/2000), observation over a period of months indicated that this complex process did not happen without agency.

For the implementation of a useful and viable information system, it was important that some way should be devised to mediate between the understandings and perceptions of the different players or stake holders, and to find the commonalties between them. By the time the active participation of Ms A, the HISPP trainer, had come to an end there was little indication of the existence of an 'information culture' or of 'ownership', other than rhetorical statements.

At this stage the HIS was perceived by nursing staff in South Peninsula Municipality (SPM), who collected, collated, captured and forwarded the data, as an "imposition from above, from management" (field notes: 17/3/2000). The RMR and the data required were not really designed to address the facility-level information needs of staff and a deep concern was expressed that the RMR did not reflect the content and quality of the work done.

In the case of community health centres (CHC's) run by the Provincial Administration in South Peninsula Health District, the RMR was collated by an Information Officer, an administrative staff member specifically trained for this purpose at workshops presented by the HISPP trainer. Although nursing managers said that they utilised the routine monthly report (RMR), they complained bitterly about medical staff who did not complete the forms. The common perception was nevertheless that the RMR:

> *«Is purely what I would call numerical data, you know: how many patients do you see, how many patients do the doctors see, and how many patients does the sister see. It doesn't tell you really very much about the problems of the centre», or «we basically have two sets of data. Those we keep for ourselves, we have worked out over the years our own data sets and we rely on it for the running of the clinic. The RMR is stats we keep for province.»* (Nursing Managers).

According to Braa & Hedberg (n.d.):

> «When the bulk of health staff are engaged in collecting data for others, when they have no influence over what they collect, when they are barely involved in analysis of data, when computerised tools used are inflexible 'black boxes' reducing their operators to mindless keyboard pushers, when they don't get feedback and don't use information for local management – then the structures thus constituted are those of disempowerment. Given this, it is obvious that such information systems and technologies are not neutral but have politics, meaning and behaviour inscribed into them.» (see Akrich 1992; Pfaffenberg 1988; Winner 1986).

Previous research indicated that existing structures and power relations were often reinforced by the ways in which information was processed and disseminated. The fact that the kind of data processed as well as the purposes for which it was used were often indicative of dominant paradigms – whether these were organisational, in terms of constructions of the 'validity' or trustworthiness of certain kinds of knowledge or whether they were aimed at 'local' (clinic) or managerial use was very important (see Braa & Hedberg n.d.).

Who has access to information, as well as the ways in which it is utilised for making decisions, is representative of existing paradigms and relations of power and can reshape social 'contracts' in a variety of ways. Research has shown that:

> «Data/information is often either not used at all, it is used because information symbolises a commitment to rational choice, it is used as a weapon in dominance games or is subject to 'strategic misrepresentation' (Feldman, March, 1981) or e.g. to support policies (e.g. macro-economic cost-cutting or privatisation) not directly linked to health policy targets.» (Braa & Hedberg n.d: 4).

For a health information system (HIS) to be implemented in such a way that it became useful to and was utilised by decision makers at all levels, a long-term, relatively intensive process of change in a shared organisational template and body of learned behaviours and systems of meaning had to be developed. In the case of HIS, this included the acquisition of the 'language' or code of information systems, its distinctive techniques and its products. Ultimately, staff had to utilise this framework in order to make judgements and to guide their understanding and behaviour. Within the health care system itself there were a variety of learned values, norms, beliefs and practices shared by health-care givers that guided their thinking, decisions and actions in patterned ways (Pickett 1993). Such a shared framework is normally effective enough to be considered valid and to serve as the shared basic assumptions of a group that, in turn, use it to solve problems (Schein

1992). However, as Kaufert and Putsch (1997) point out, even while sharing similar culturally informed norms and values as health care providers, there might be differences in understanding and approach as to what is regarded as important principles and information in the decision-making process for service delivery at particular facilities or levels, and of what is necessary for such a process to happen. This in turn impacts on ways in which an information system is perceived, approached and utilised or not utilised.

This was particularly apparent in the Community Health Centres managed by Provincial Administration of the Western Cape (PAWC) and, according to a Nursing Manager:

> *«We have the quantitative measurements like the RMR ... but we never get feedback on our statistics. Of what happens. How we are doing. We collect and collect... The RMR could be much more useful, so we can actually plan and adjust our services according to the weak spots and the shortcomings. But the information has to be accurate. We do not have information about patterns of patients' use of the services... The doctors are not really collecting information for the RMR... they are reluctant and we have to keep after them. So, we have a kind of blind spot in our services when it comes to the doctors..., each day has its own complications and you have to deal with it. I plug the holes so we can keep on for the day. It is a bit like trauma management – you never quite know what to expect, something can throw a spanner in everything, and you have to deal with it. These kinds of emergencies I am sure will affect the RMR because the stats will not be accurate. Mrs. P [information officer] collates the RMR but we just fit it into our daily routine, ticking off the things. Mrs. P collects all the statistics at the end of each week. Our information goes a long way – from here it travels to Fish Hoek and from there it goes to Woodstock and we do not have email facilities, so it goes with a stiffie, sometimes the stiffie gets lost. We send the internal post to Woodstock – the internal post has many stops and it takes a lot of time to get it around... Generally the information is available and they (management) can inform each other or not at all. I do not know if they can be made to inform each other. A CHSO is by nature more complex than a clinic and there are all kinds of different professionals working here. We should be informing each other but we do not necessarily do that.»*

At community health centres (CHC), two kinds of data were collected – those prescribed by the health information system (HIS) and those necessary for providing services at facility level, for the planning and execution of daily tasks. The latter was based on records kept by nursing and medical staff for the needs and purposes of the facility. Such data were analysed as the need arose and utilised to:

> *«Get a picture of the situation, where we fall short, how are we doing in terms of the budget.»* (Interview CHC).

By contrast, information collected for the Routine Monthly Report was seen as:

> *«Stats that go to head office... we don't get any information, no back-up, no feedback.»* (Interview CHC).

Although staff collected data on the tick sheets on a daily basis, it was not analysed or seen as particularly useful. According to a Nursing manager of a CHC:

> *«The data to me just appears purely numerical. You can't make an analysis that would influence how you're going to plan for programmes. To me data if it tells me that 20 percent of my patients are hypertensive the only effect that will have is perhaps on ordering the medication. But it doesn't tell me that the patient is late for his medication, what percentage is late for their medication, what percentage is on time. It doesn't tell me the patterns of how they use the clinic at all. So, to me it's not applicable. I mean obviously the powers that be would like those numbers but I don't... Apparently that data has been stipulated by national government, that's what they want and that's got to be done. Whether we want to do, it or whether we don't it doesn't matter; it has to be done. But we are not any way prevented in collecting what data we think is applicable. So, it's actually up to the sister or the nurses in charge of the facility. As long as she enters the data that they want. But I think most of the managers are now beginning to understand that they're going to have to draw up some sort of relevant data collecting to use later on.»*

In the case of facilities managed by South Peninsula Municipality there was an extended process during which staff learned to cope with often disparate approaches to and views on the kind of information required for good service delivery. In another sense, they also had to learn to mediate between their everyday working and the world of computer technology and information science. The success or failure of their attempt to negotiate the borders between the two depended on the assistance they received and their gradual socialisation into the HIS. In this process someone, or more than one person, had to assume the role of cultural broker.

Ritualising and mediation

Moving between virtual and everyday realities

The HIS is basically about standardisation – bringing together potentially heterogeneous information provided by various people through a variety of methods and transforming it into 'facts'. To become a fact, the information has to be constructed as being 'true' and 'correct' by a number of people over a period of time. It becomes a kind of prototype of information circumscribed by particular parameters, for example certain minimum and maximum values, and is routinely sought, utilised and increasingly perceived to be true. As the information is widely disseminated through information technology it 'hardens' and becomes fact. According to Braa & Hedberg (n.d.), information is often only utilised to a limited extent for daily management, budget allocation and long–term management. Although initial documentation on the implementation of the health information system (HIS) stressed that staff who collected information should also have a say on deciding indicators and designing data collection instruments (District Health Information Guidelines 1998: 165), various participants in the study believed that the routine monthly report (RMR) was pre-designed to meet the minimum data requirements needed for "management decisions" (Fieldnotes 14/4/2000). Getting staff to use it, to take 'ownership' of it, required that they understood that the reliability of the information depended on the people who collected it at the baseline level, entered it into the system and saw to it that entries tallied. Staff at facility level had to be able to access and assess the statistics and to understand it, in order to use it for comparative purposes.

Despite many inherent contradictions, the institutionalisation of the HIS and the RMR in South Peninsula Municipality was fairly effective. To a large extent its success was the result of a constant seeking of common ground between the different participants, this occurred through a process of cultural brokerage and the subsequent ritualising of the presentation of the RMR. According to Clarke (1978), a cultural broker should be able to envisage two or more systems. In the case of the HIS and the RMR it involved a simultaneous understanding of how knowledge and what constituted 'true or valid facts' or information in a specific situation were constructed from different perspectives, like the technology-driven world of information systems and the everyday world of health care provision at facility level. The broker had to find synergies that made the process meaningful and beneficial to all participants. The process of brokerage was an active and increasingly ritualised one of exchanging information, communicating, instructing and mediating between the expectations, beliefs and decision-making practices of the various constituents (Pickett 1993). The cultural broker elicited the various participants' own constructions and understanding of information, unlocked its social and personal meaning and, in conjunction with them, attempted to assess its potential impact on their work-load, role and position in the workplace. Such a process gave weight to the knowledge of people who feared that they might be negatively affected and it created an opportunity to address these concerns. The broker compared the framework of values, beliefs, and practices concomitant with the health information system (HIS) with that of the staff at facility level and assisted in developing a shared model, which maximised the benefits of both systems (see Hall *et al.* 1998).

The role of broker was taken by the district HIS co-ordinator for South Peninsula Municipality, Dr B, who constantly tried to mediate between the particular paradigm from which HIS originated and the everyday working world and knowledge of the staff responsible for generating the information. In the process, she continuously seemed to seek ways to assist staff in understanding the connections between the technical computer-based information system program initiatives, their own work experience, and the needs of the workplace.

Brokering

According to the narratives presented in the introduction, the presentation of the RMR entailed a performance that was differentiated from the ordinary and was enacted at specific intervals in specific spaces. The process of ritualising the RMR as a performance did not happen immediately. In the case of the South Peninsula Municipality facilities, the health information systems pilot project (HISPP) site meetings, where the RMR was promoted, were initially somewhat disjointed gatherings. Despite working in accordance with a HIS agenda, nursing staff broached all kinds of indicators and problems, which they deemed important for their own facilities. The format of the meetings began to change under the guidance of Dr B. At the end of each meeting, staff from particular facilities were assigned tasks concerning the RMR, which they had to present at the next meeting for discussion. Dr B increasingly stressed that the RMR involved a minimum data set that had to be used for management decisions – she also continuously emphasised that clinics had a management function and that the information could be potentially useful for staff. Consequently, ways had to be found to use both the RMR and to develop data sets that were streamlined for the needs of the particular facility. Clinics needed to develop their own statistical bases, while also beginning to use the RMR to understand how their own clinic functioned and how it compared to others. In this process Dr B gradually mediated not only the understanding of the RMR but helped to set up the conditions which would in time turn it into a regular ritualised pedagogical event and display.

Initially meetings began with Dr B referring briefly to the purpose of the RMR and the need for everyone to use and report in this format of a minimum data set. The complex process involved in brokering between different understanding and experiences and turning it into a performance of the health information system, (HIS) is highlighted by the following vignette.

> «The participants were seated when Dr B entered and sat down. All talking ceased and staff turned towards her. She welcomed staff, went through the minutes and set out the agenda. Mrs D, from C clinic handed out graphs and lists, which represented a list of all the medication, dispensed in the clinics over the period of one month. All participants first studied the documents, then sat back and looked at Mrs D, waiting for her presentation. The RMR provides for two categories – All prescriptions issued and All items dispensed per script. The district HIS co-ordinator, Dr B, looked at the list of medication, watched the presentation and said the most expensive drugs were the ones for TB "but it is to be expected, you have a lot of TB at C [a clinic]. But this, why is so much [a certain TB drug) dispensed? You can use... it is less expensive".
>
> The PN (professional nurse) responded that a particular doctor prescribed it and seemed to prefer it, because she said it was "better". Dr B also wanted to know why so many antibiotics of a particular kind were dispensed. A long discussion followed on the habits of local clients who "fill up their prescriptions", "stock up" and "hoard" drugs. Clients apparently preferred anti-biotics over other medication and like to have some stored in the refrigerator or a cupboard. After discussion it was decided that a small campaign will be run to alert people to the fact this can be potentially dangerous and to request them to return unused drugs to the clinic" (field notes 14/4/2000).»

Although the RMR provided for the generation of statistics concerning medication, the two categories used gave no indication of the complexity of the process of dispensing medicine and of client's beliefs and practices concerning medication at local level. The discussion which ensued showed that medication, and the belief in what was efficacious or not, related to the ways in which people understood medicines at a local level. Medicines were thought "to have the power to produce an effect", but efficacy may have different meanings for those people embedded within the framework of natural and/or medical science (Reynolds Whyte & van der Geest 1988: 7) and for those who do not share this conviction. In this case, the nursing staff themselves mediated between the specific understandings of their clients, their expectations for treatments and drugs, of the roles of the health care workers themselves and communicated this to Dr B. The particular doctor's preference for a certain 'brand' of drug also needed to be unpacked and contextualised. Together, the doctor and the staff devised a meaningful and beneficial way to meet the needs of the clients, while also streamlining the dispensing of drugs in a cost effective and potentially less dangerous way, since some of the hoarded medication inevitably expired. This complex interchange was finally reflected in terms of two statistics in the RMR.

The following vignette from a quarterly tuberculosis (TB) meeting illustrates the intricacy of brokering between the local working worlds of nursing staff and the needs of the restrictive RMR in a way which made sense to the participants and showed that the data collected were potentially useful:

> «Staff are busy checking the zero tables and entering the date into the computer for the TB quarterly report. The district HIS co-ordinator, Dr B, comes into the room. It immediately becomes very quiet, the lights are switched off and the different presentations appear on the screen. Dr B points out the form of Clinic A. She says»:
>
> *«You sent 20 smears away on one day and nothing for the rest of the week. People will look at it and what will they say? What are you doing?»* [Dr B].
>
> *«We are not working every day, but doctor we are»* [Professional Nurse Practitioner].
>
> *«No, I am not saying you are not working. I will say you work on the old system where you only do TB on a Wednesday. You must remember these forms become the truth. That is what happens. You need to spread sending away specimens, do that on other days as well. The patients are also watching you. They see you do it on a specific day. Then they come that day. Spread the sending of the specimens over the week, to make people see it happens every day, they will learn that fast enough and come every day. Remember they also learn from watching you.»* [Dr B] (Field notes 6/10/2000).

In the above vignette, Dr B first elicited the way in which the service providers thought the statistics might reflect on the way they did their work. She then identified common norms and values between the objectives of the HIS and the stated societal responsibility of the facility. It entailed a learning process whereby staff could recognise a particular trend in service delivery, as well as the positive potential of the RMR for understanding their own facility-based working practices and how they could change them to benefit the surrounding community. To ensure that the learning about, implementation of, and practices around the HIS were both effective and sensitive to specific groups, the broker had to be able to assess the importance and history of certain issues as they related to the particular facility and the community it served. Strengthening and intentionally recognising these connections to the local facility's reality compelled staff to explore their own traditions of service provision. Brokering between participants of practical learning initiatives such as HIS built bridges and made connections that could help all involved understand the significance of the effort.

From the first HIS meetings mediated by Dr B, she stressed the diverse interest groups involved in the implementation of the information system, namely the facilities, South Peninsula Municipality, the Provincial Administration of the Western Cape and the national government. Each of them had its own perceptions of the information needed for good, rational and cost-effective management of health care services. At the South Peninsula Municipality level the most important interface was between the facilities, where the information was collected, and the more generic needs of the HIS programme and 'management'.

According to the District Health Information Guidelines (Health Systems Trust 1998:166):

> «Information from routine monitoring often only points to the existence of a problem – it does not usually explain the causes of, or develop solutions to the problem...»

At a meeting of facility managers in South Peninsula Municipality, the district HIS co-ordinator, Dr B, stressed that staff:

> *«Need to be aware of the stats to reflect and understand on it. You need to always be able to link it up to what happens out there. You must know your facility, know the norms of your facility. Take E clinic, their TB stats look bad. Why is it?»* [Dr B].
>
> *«Our TB cases are low, one person died»* [Professional Nurse practitioner].
>
> *«So if the TB numbers are low, but if one person dies, it looks like a statistical disaster, if you know your facility and you know your facility's population you will be able to say it looks bad on paper, but in reality it is not so meaningful.»* [Dr B] (Fieldnotes 13/6/2000).

By giving staff the opportunity to express unique as well as shared features and practices prevalent at each facility, by stressing the overall commonalties between all the elements involved and brokering between them, staff came to accentuate the common ground within and between facilities, community and management constituencies. As a result of the brokering role of Dr B these efforts were increasingly collaborative, over time, led to more effective, and sustained HIS programme practices.

Over time the mundane actions of "learning HIS" (field notes: 17/3/2000) evolved and gradually shifted into something else, that is, regular ritualised performances at the monthly HIS site meetings (2), Facility Managers Meetings (3) and quarterly TB meetings (4). This process became identifiable through specific performances, which were ordered and spatially and temporally distinguishable from the ordinary (see Kapferer 1984: 194).

Ritualising performance

According to Bell (1992: 74) ritualisation can be understood as a:

> «Way of acting that is designed and orchestrated to distinguish and privilege what is being done in comparison to other, usual quotidian, activities.»

Thus, ritualisation is a process, which involves the situated performance of social practice (Hughes-Freeland & Crain 1998:2). I accordingly move away from Turner's (5) linkage of ritual to the supernatural and rather situate my field observations and interviews in the transformation of ordinary practices into ritualised and performative events to process and present information. I do not give much attention to ritual as representation of the socio-cultural order, but rather draw attention to the process and the didactic nature of many ritualised events (see Handelman 1998: xv).

As indicated earlier, in the case of South Peninsula Municipality the HIS and the RMR regularly formed part of particular kinds of meetings. Once the meeting came to this phase, graphs pie charts, tables or 'raw' statistics were distributed. Dr B gave a short overview of the latest information concerning the RMR, followed by staff presentations. The various indicators for the RMR were displayed on a screen, their meanings highlighted and comparisons made between clinics. In the case of tuberculosis (TB) indicators, Dr B also announced at the end which clinic had the best results as reflected in the RMR. Amidst applause, she then rewarded the winners. Over time, the RMR as a performance developed a distinguishable pattern and sequence, with particular directives. What was happening was the emergence or even the 'invention' of ritual. This understanding was supported by documents used for training in the field of health information systems in the Western Cape, which stressed the need for:

> «Creative analysis, interactive interpretation, ritualised presentation and use of information.» (6)

While ritualising in this way often is not 'officially' supported, the opposite seemed to hold in the case of the performance of the RMR (see Grimes 1990). The participants themselves did not necessarily define it as ritual but others, including myself, interpreted it as such. Furthermore, the necessity of cultivating it was stressed in the health information system documentation. Nursing staff who participated in these performances often referred to the ways in which meanings were articulated in this performance, to bring into existence the reality of the services rendered, its problems, strengths and weaknesses (see Rappaport 1979).

As in the case of the narrative presented at the beginning of this chapter, nursing staff of South Peninsula Municipality stressed the importance of the presentation of the RMR as performances:

> *«Narrative reports, graphs, charts, what it was before, how it increased, where are problems. We look at it each time, regularly, in a formal way and you start to see [when] something is wrong. Maybe someone did not collate the stats correctly and you can go back to them and say the definition is this and are you doing it that way. Also*

> *to see how many of the sick children do we really see. Even if the day hospital sees many of them. When we go to meetings and we see that we normally see 1000 children but this week we saw 2000 then we can see we were extremely busy, and yet you had the same complement of staff and maybe less, because people were off sick. And how you coped. The charts are quite useful and also the pivot tables... we have learned to analyse it... I put it up... and show we have dropped and we compare it to other clinics. It is useful to tell the amount of incidents, whether it is on the increase or decrease. It is a comparative thing across SPM [South Peninsula Municipality]. I keep these things and I can tell you how we have been doing over the whole year. I understand it pretty well now. We worked through it again and again and again and in the end it makes sense to you. You can read it and know what it says, but it is a process. It does not just happen. It becomes familiar, you start to trust it, it becomes more reliable, and more useful. It has been a long process. Last night when I left, I thought how could we have so many family planning in two days of the month. Then I pick it up and see I made an error, I should have added the next two days to that, thinking that it is the week – it is the last two days of the month, so it comes out as two odd days maybe. So you learn to [with the presentations of the RMR] interpret the things you put on here. You need to be familiar with it, and when it is familiar and you can interpret it, it becomes more reliable for you. But that was a very long process. It did not just happen after those workshops. We work through it again and again with Dr. B and with ourselves. It is at least somehow reflecting what we see here every day in reality and we can start to pick up when it does not really reflect what we see every day. You have an understanding of what goes on in the clinic from a lot of things and through this process the RMR has become a component of that – we can start to calibrate the two. Also, because it becomes familiar, it becomes interesting. The format for the presentations has become the same. So you can compare what you did last month – you had a slack period there and you start to compare, are it seasonal, is there some other reason. Also Dr. B is a fanatic about presenting the RMR and she pushes us to deal with it. She takes the trouble to sit with the zero tables and say, no you made a mistake here, let's go through the book. We needed for her to pick up on all those things and then help us to see what, how it relates to us and how it becomes useful, what it reflects and when it is wrong.»* (Professional Nurse Practitioner).

In a sense "show time" (see above), or the performance of the RMR focused on the entire health system including planning, policy, and assessment of services and to an extent the health status of some communities. It was supposed to represent the status quo "out there" of " services at base line", who the "clients" were, "the problems" and relationships and comparisons between different facilities. This was done through a small number of objects like the "narrative reports", "zero tables", "pie charts" and "graphs" which also symbolised the ethos of community health care and the health status of the community to which the services were delivered (see Grimes 1990: 44). At the same time, it seemed to be somewhat paradoxical and incomprehensible to some. As broker, Dr B sustained the main role and narrative in the performance, but there was a great deal of ambiguity in how it was interpreted by her, by other participants and by myself as 'participant observer'. Although it was not understood "all the time", there was nevertheless "a pattern" and staff went "through the motions". According to Bell (1992: 35) participants embody the schemes of perception and interpretation of a ritual and then apply them in the everyday world:

> «Ritualisation is, therefore, a type of creative socialisation.» (Bell 1992: 35).

The ritualised performance of the RMR ultimately communicated its meanings to the participants and to the observers, it involved a process of reflection. In 'acting out' the RMR through the mediation of Dr B a synthesis, or 'calibration', could occur. In enactment (or doing) the meaning of the RMR and the HIS was formulated and articulated and came to be understood by the participants (see Bell 1992; Schieffelin 1985).

As stressed at the beginning of the chapter, there are underlying issues concerning power and control related to the HIS and this was to some extent reflected in the performance of the RMR. After all, it was highly unlikely from the beginning that the role of 'leader' of the performance could have been taken by anyone else (for example a Professional Nurse practitioner). Yet, as stressed by Bell (1992: 221-222):

> «The type of authority formulated by ritualisation tends to make ritual activities effective in grounding and displaying a sense of community without overriding the autonomy of individuals or sub-groups.»

The performance of the RMR accordingly also brought about a sense of cohesion and of solidarity between participants. Although not everyone agreed with it in private, the presentation the RMR was a visible and public performance of the very principles of the public health approach which is supposed to work for equity, be objectives based, centralised, simple, flexible and standardised (Field notes: Health Information Summit: 20/6/2000).

Conclusions

In clinics managed by South Peninsula Municipality, unlike the facilities managed by the Provincial Administration of the Western Cape (PAWC), the RMR had gradually become a performance. It had developed a particular, bureaucratic and didactical design through practice. The 'performance' of the RMR happened within particular spaces and time frames and had become ritualised, visual displays of health care classifications and systematisation.

The entire process and the successful implementation of the Health Information System, including the use of the Routine Monthly Report, depended on the agency of different organisational bodies and people. They did not necessarily have similar expectations or requirements and they brought different levels of expertise and understanding to the task. In clinics managed by South Peninsula Municipality, the process and the relative success of the implementation of the HIS and the use of the RMR hinged on this pivotal process of mediation by cultural brokerage – to explain its intent, give meaning to its content, test its integrity and support and to share it with others. The roles of culture brokering and of ritualising made it possible for the implementation of the Health Information System to deepen and develop over time. It helped to manage the process in a fragmented setting and to de-mystify for the staff the given information system, its knowledge base and technologies while enabling them to utilise it to understand their own facilities, patient needs and services rendered. It made comparisons possible, and individual planning could be tailored accordingly. Where this did not happen, as in the case of facilities administered by the Provincial Administration, there was scant if any evidence of a diffusion of the HIS as a 'culture of information'.

Acknowledgements

I want to thank Dr Virginia Azevedo of South Peninsula Municipality, Ms Sylvia Saffers, and all the clinic managers and staff responsible for HIS for allowing me to attend their sessions and to interview them. My thanks also to Dr Els van Dongen for valuable suggestions and input. Lastly my thanks to HST and NUFU for financial support.

Attachment 1 – Routine monthly report: PHC services Cape metropole region (14/8/00).

District:

Facility:
Month:
Completed by (Print Name):

Data Category	Data Item	N	Week 1	Week 2	Week 3	Week 4	Week 5	Total
Total Attendance at Facilities and on outreach visits	Under 5 years of age	01						
	5 years of age and older	02						
Growth Monitoring	<3rd%ile & = >60% EWA <5 yrs (new)	03						
	<60% EWA <5 yrs (new)	04						
	Growth faltering / failure <5 yrs (new)	05						
	Children under 5 years Weighed	06						
First Contact with Health Service	Babies exam. 1st time up to and including 6 weeks	07						
Development Assessment	Children under 2 years who had develpmental screening done	08						
	Children under 2 years with suspected developmental delay	09						
Prevention Care	Children <5 years seen for prevention services ONLY	10						
Mental Health	Visits Old Clients	11						
	New clients seen	12						
	Clients referred to 2nd level	13						
	Clients referred to 3rd level	14						
	Psychiatric discharge patients seen	15						
Curative Services	Seen by MO	16						
	Seen by PN for curative	17						
	Seen by PN and referred to MO	18						
	Children <5 years	19						
	Children <5 years diarrhoea (new)	20						

Segue tabella

Data Category	Data Item	N	Week 1	Week 2	Week 3	Week 4	Week 5	Total
	Children under 5 years with lower respiratory tract infection (new)	21						
	STD (new)	22						
	Males with PUD (new)	23						
	STD Contact Slips Issued	24						
	Number of STD Contacts Treated	25						
Reproductive and Women's Health	Family Planning Clients Seen	26						
	Teenagers <18 yrs using Family Planning Method	48						
	Oral Contraveptives Issued	27						
	Depo Provera given	28						
	Nuristerate given	29						
	IUCD's	30						
	Condoms issued	31						
	Emergency contraception	32						
	Referred for TOP	33						
	Cervical (Pap) smears 30-59 years old	34						
TB DOTS Attendances	Daily TB DOTS Attendance	35						
Personnel	Actual nurse-days worked	38						
	Actual doctor-days worked	39						
Maternal	Booking visits <20 weeks	40						
	Booking visits => 20 weeks	41						
	Antenatal follow-up visits	42						
Chronic Care	Total chronic cases Diabetes mellitus Hypertension Epilepsy							

Segue tabella

Data Category	Data Item	**N**	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Total**
Other	Seen for any other services	47						
Immunisation	BCG at Birth	49						
	TOPV	50						
	DPT; Hib; OPV; Heb B-1st dose	51						
	DPT; Hib; OPV; Heb B-2nd dose	52						
	DPT; Hib; OPV; Heb B-3rd dose	53						
	Measles 1st Dose at 9 Months	54						
	Measles 2nd Dose at 18 Months	55						

Notes

(1) South peninsula health district includes the southernmost part of the Cape peninsula. It roughly stretches from Retreat to Muizenberg and Fish Hoek, but also includes Houtbay. The suburbs involved are: Constantia, Tokai, Noordhoek, Fish Hoek, Simons Town, Ocean View/ Kommetjie, Houtbay, Plumstead/ Diepriver, Ottery/Wetton, Lotus River, Southfield, Bergvliet, Retreat/ Steenberg, Seawinds, Grassy Park, Pelican Park, Muizenberg, Lavender Hill. Due to natural barriers (mountains) and long distances in-between, some communities are relatively far from the nearest health facilities. The district includes some of the most affluent suburbs in the Cape Metropole, as well as some of the most disadvantaged (mostly informal settlements) communities in the city. At the time of the research services were provided by the Provincial Administration of the Western Cape (PAWC) at Community Health Centres and hospitals, while South Peninsula Municipality provided services at clinics and day hospitals. The services were merged in November into a wider unit called he Cape Town Unicity (see South Peninsula health District. Joint Planning 2000 Discussion Document).

(2) This is a forum in which all the staff who are involved in collating the Routine Monthly Report participate. In the case of the South Peninsula Municipality all staff working in clinics are supposed to be able to do this work eventually. Accordingly all clinics will send at least one representative, even if this person is not actively involved in the process at the time.

(3) All clinic managers of South Peninsula Municipality are represented on this forum.

(4) All clinics send representatives to these meetings.

(5) Turner (1967: 19) defined ritual as «prescribed formal behavior for occasions not given over to technological routine, having reference to beliefs in mystical beings and powers.» Turner relates ritual, religious beliefs and symbols, and expresses this interrelatedness in another definition of ritual as «a stereotyped sequence of activities involving gestures, words, and objects, performed in a sequestered place, and designed to influence preternatural entities or forces on behalf of the actors' goals and interests» (Turner 1977: 183). According to Deflem (n.d.) Turner's definition of ritual essentially «refers to ritual performances involving manipulation of symbols that refer to religious beliefs».

[6] Documents for M.Sc in Public Health (Information Systems Track), University of the Western Cape. 2001. Health Information Systems an Advanced Course. Available on: http://www.siu.no/noradcat.nsf/852561.../98f28bf60323c5bac125694a0042ec38?OpenDocumen 5/19/01: p4.

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AM
Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 123-139

Nutritional discourse in food advertising.

Between persuasion and cacophony

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1. Introduction

In industrialised countries, which may still be influenced by the debate of the 1960s and 1970s that highlighted the possible social effects of advertisements on society at large (1), advertising is considered to be one of the tools that, according to institutional and popular opinion, best generate some of the evils that are characteristic of the new industrial order. Public sees food advertising as a phenomenon that promotes disturbing trends in health matters because it encourages homogenisation of the diet, consumption of foods that are hardly nutritious or are completely innutritious, and disinformation about the characteristics, properties and functions of the goods it promotes. We shall see, however, that such a relationship between cause and effect is difficult to prove.

We must first discuss what kind of products is advertised. Advertisements for foods are heterogeneous *per se* because the foods themselves are heterogeneous. Food advertising therefore makes public products of foods that are recommendable and foods that are not recommendable, i.e. foods that are nutritionally "good" and foods that are nutritionally "bad".

There is also a more general problem. To assert its influence on the market, advertising constantly needs to re-evaluate its activity, but the relationship between a particular advertisement and immediate consumption is not always clear. Advertisers themselves recognise that many variables make it difficult for them to make in-roads. The effects of advertising frequently are mixed up with socio-demographical factors, and the cause-effect relationship between advertising and other essential variables is difficult to identify. Multiple empirical analyses – from econometric evaluation and analysis of perception, recall and memory, motivation and changes in attitude, to explanations of its objectives provided by the various disciplines – show us how difficult it is to limit its effects (2).

Although these problems exist, as do those related to saturated advertising space and the constant attempts people make to avoid seeing advertisements (e.g. channel switching), it is true that articles that are the subject of advertising campaigns have a specific advantage; they are an advertised product. Despite people's negative opinion of publicity, public recognition validates the articles in the advertisements; it recognises them, makes them familiar, identifies them and, more importantly, gives them a social significance (Leiss, Kline and Sut 1986 and Mckraken 1988). A different matter is whether the people who receive these messages consider them to be as good a source of information as other sources (the family, institutions, and doctors). The passivity with which its audience receives an advertisement calls into question the source's intentions (3). On television, one advertisement is quickly followed by another, so the audience processes very little of the information. The audience also knows that the source is paid to say what it does.

This is detrimental to how people receive the advertisement, but it does not mean that they do not believe it (León 1989 and 1990). The public tends to regard this source as something trivial and it is therefore difficult to make an in-depth evaluation of what is shown. The source's influence, and that of its message, is produced by *osmosis*; the message is persuasive and requires one mentally to process the information and the source that supports it. Consumers are not so much invited to change their habits as to change their products. Brand loyalty does not seem to be of vital importance, so to lack this loyalty or the beliefs that maintain it, is not especially perturbing. This is why in advertising the lack of the source's objective credibility is not a barrier to producing persuasion or creating affection for a product. In this respect, advertising meets its primary objective: it takes its message to its target audience, whom it persuades to buy.

All this means we must concentrate on how this promotional work – generating and spreading information about diet – is done; what kind of messages are the advertisements built on, which arguments do they tend to use, and are the form and content of these messages helping to increase the cacophony and the disconcertion consumers show every day when trying to decide what to eat?

I therefore considered a number of studies that have established a direct relationship between advertising and the consumption of foods. These included my Ph.D. on the population of Barcelona (Gracia 1996 and 1998), in which I made a field study of eleven domestic groups (thirty-three interviewees altogether) that were chosen for their analytical significance (variables such as the type, structure and size of home, and the group's activities, age, and ethnic origin). I used several qualitative techniques, particularly in-depth interviews that contained a section on attitudes to advertising, an advertisement-recognition test to detect any anti-advertising a-priorism on the part of the interviewees. The interviewees were shown various elements of recent and not-so-recent food advertisements in the form of a game (jingles, slogans, famous people, arguments). They then had to establish the links between products, brands and advertisers, which evaluated how much they were able to recognise and recollect. This made it easier later to introduce the in-depth interview on advertising and obtain a more accurate qualitative information about some of the hypotheses we have made in this paper. Data from these two technical resources were then compared with the answers on the criteria for selecting and incorporating new products, and with the products found in the interviewees' kitchens and pantries, which had previously been inventoried.

I also drew up a file of Spanish food advertisements from the sixties to the nineties in order to selectively analyse the presence of nutritional discourse during this period and assess which arguments it used. For this, I designed a form for extracting content. This form provides detailed information about the product and how it is advertised. It contains seven sections, each with its own subindexes and codes.

– The first section deals with the advertisements' technical characteristics (product, brand, advertiser, year, medium, support, and format).
– The second deals with the characteristics of the product (state, presentation, requirements for consumption, origin, an estimate of its nutritional value, ingredients, and food group).
– The third deals with the products position (what requirement there are for consumption, how often it is consumed, whether it is seasonal, and what place it occupy in the diet).
– The fourth describes the structure of the advertisement and refers to the verbally transmitted message (oral and written) and the visually transmitted message (the images). It particularly records the formal characteristics of the language of advertising, the possible economy of words, the weight of semantics, denotation/connotation, or the communicative resources, in terms of narration/expression or motivation (functional attributes, advantages, benefits, desires and values associated with the advertisement, humour, drama, witnesses, etc.).
– The fifth analyses the context of the message in detail. It is divided into two subsections: practical and symbolic representations and discursive arguments. The first subsection refers first to the environment in which the product is seen (family, home, leisure, work, school) and the stage it is seen in (production, culinary prepa-

ration, consumption) and, second, to the kind of people in the leading roles and their respective functions. The second subsection refers particularly to the predominant theme of the message.

- The sixth refers to the intended communication and takes into account the aim of the advertisement. Is it trying to launch a new product, maintain its position in the market, or change the product's image? Is it in response to a particular promotion? Is it informative?
- The seventh defines the real and potential target audiences (consumer and/or buyer), and whether these profiles are deduced from references in the advertisement, from knowledge about the kind of person that uses such-and-such a communication medium, or simply from information in profiles of buyers.

The form was used with the more than 400 television, newspaper and magazine advertisements that make up the file. Medical-nutritional discourse was the dominant line of argument in 40% of these advertisements. We shall now look at two examples.

2. *Advertising, food and health: case studies*

In general, studies of the relationship between advertising and attitudes to food have concentrated specifically on demonstrating how advertising influences the consumption of foods and, in particular, on its negative effects for people's health. They have highlighted the special vulnerability of certain sectors of the population, e.g. children and women, regarding the impact of advertising. Such studies are, for example, those by Fox (1981), Taras *et al.* (1989), Igun (1982) and Hung, Ling and L-Ong (1985) (4).

Fox (1981) begins by saying that many Americans are exposed to television advertising every day. Children, who watch television for an average of 29 hours per week and see nearly 25,000 advertisements a year, are even more exposed to it than adults are (5). In the author's opinion, very young children are unable to distinguish between advertisements and programmes and are not aware of the advertisements' aims at persuasion. The study uses samples of children of 4 and 9 years of age and investigates the relationship between the type of food advertisements (products with a low standard of nutrition, pro-nutrition advertisements, no control) and the standards of nutrition in the child population. The effects of advertising are evaluated by testing behaviour at meal times and by other complementary techniques based on direct observation.

The study shows that the children pay attention both to programmes and advertisements, although there are clear cognitive differences between the two age groups. Older children can distinguish between advertisements and programmes better, are more conscious of their aims, and are noticeably suspicious of advertisements. Despite these differences, in both groups the children with the worst levels of nutrition are those who increase their calorific consumption more significantly via foods and drink of low nutritional quality that are advertised on television. Fox suggests that one way of inducing positive effects in children is to expose them more frequently to advertisements for products with high levels of nutrition.

Often, however, the problem is not with the children but with their parents. The study by Taras *et al.* (1989) of the United States confirms that the influence of television on children's diets and physical activity must be taken into account when developing strategies for preventing obesity and the sedentary way of life. This interdisciplinary group believes that the influence of publicity is quite definitive. It demonstrates that the frequency with which children ask for foods that they have seen on television is the same as the frequency with which they are advertised. This study includes some interesting data; the parents of the children in the sample perceive that television influences family shopping patterns via their children's demand mechanisms. The most frequently ordered and purchased foods are those with a high sugar content, followed by those rich in fats and salt and then those that are low in sugar, salt or fats. The researchers also show that there is a strong relationship between the proportion of foods of each category bought and ordered by the sample population and the proportion of foods in each category advertised on television. At the same time, they detected a significant correlation between snacking (a continuous form of eating based on rather unstructured meals taken alone) while watching television, and the quantity of advertised foods that are bought or ordered. The authors agree that parents also need to be educated, since the parents of the children who watch many hours of television buy them foods advertised in this medium more frequently than other parents do.

Other studies investigate how publicity influences highly specific nutritional practices and like breast-feeding (Igun, 1982; Hung, Ling and L-Ong, 1985). Carried out in developing countries, they reveal the factors behind the changes in breast-feeding practices of mothers in Maidiguri and Hong Kong, respectively, and highlight the influence exerted by advertising in non-Western countries.

Igun's (1982) study was based on interviews with 250 illiterate mothers of low-income families from Maiduguri (Nigeria) who attended antenatal clinic in that city. The study aimed to find out the emerging pattern of infant nutrition in Maiduguri, a centre of rapid urban development, and identify the factors behind it. It concluded that the emerging pattern is characterised by a trend for combining traditional methods with methods that have been learnt through contact with the culture of industrialised countries. The most important factors here are the media advertisements promoting the consumption of artificial milk and mothers in the elite groups. These ones, showing a strong preference for the baby's bottle, thus elevate it to fashion status in the eyes of poor, illiterate mothers with less western education, who for no other reason decide to follow their example. At the same time, Igun does not underestimate the part played by the passivity with which the medical profession accepts this trend.

Hung, Ling and L-Ong (1985) show that the situation in Hong Kong is similar. To evaluate the factors influencing nutritional practices, they studied 714 Chinese mothers of children aged between 4 weeks and 6 months and observed that bottle feeding is more common among mothers who are more influenced by professional medical people that are opposed to breast-feeding. Again this influence is strongly reinforced by the media, particularly in television advertisements that support the introduction of this new practice as one that is healthy and that can be easily adapted to any situation. Mothers who breast-feed, on the other hand, are influenced by their social networks, who advise against using the baby's bottle. The most frustrated mothers are those who breast-feed their babies without the support of their relatives and friends and who, although they may receive encouragement from medical professionals in favour of the practice, do not practise it with as much conviction as if the encouragement came from their own social networks. The data suggest that the different sources of influence and the different nutritional practices are linked. If a mother is to continue with a chosen practice, social support is essential and if this support does not exist, advertising, so repetitive and persuasive, may easily encourage mothers to wean their babies off breast-feeding prematurely. Manderson (1988), in his study of social change in Southeast Asia and the South Pacific, arrived at similar conclusions.

Judging by these results and the substantial investments advertisers have continued to make despite successive economic crises, advertisements clearly exert a certain influence on the population. For several reasons, however, we need to qualify the cause-effect relationship they are said to have on the negative aspects of the contemporary diet. Firstly, this is because people's dietary behaviour is itself complex and depends on a number of biological, ecological, economic, socio-cultural and psychological factors; the criteria governing food choices in any culture correspond to innumerable variables that depend on the context. Therefore, the material and symbolic practices for guaranteeing the diet of human groups do not include just what people eat, but also where, when, who with, how, why and what for.

Secondly, food advertisements are not homogenous in their objectives or in the articles they promote. To illustrate this let us take the following example. We classified a list of advertisements broadcast during one month (6) in terms of the nutritional content of the food they advertised. In the *least healthy* (7) group, we included goods that are high in calories or rich in saturated fats, simple sugars or alcohol. In the *recommended* group we put milk and its derivatives, olive oil, cereals, pasta, frozen vegetables, fruit, jam, honey, fresh and frozen fish, whole-wheat bread, rice, pulses, baby foods, saccharin, water, must, chocolate, sports drinks and fruit juice. The *least healthy* group included industrially produced pastries (cakes, madeleines, biscuits), cold meats (salami, etc.) and pâtés, snacks, sweets and toffees, frozen fried foods (chips, fritters, croquettes, etc.), pizzas, convenience foods, stock cubes, coffee, fizzy drinks, beer, appetisers, wines, champagnes, and two fast food restaurants that usually serve such products.

The fact that the range of products is so wide shows that advertisements promote any kind of food and, depending on how often they are shown, increase the consumption of *recommended* or *less recommended* foods equally. It is also true, however, that the distribution of these products is less balanced; many of the *less healthy* foods (pastries, snacks, sweets and fizzy drinks) are advertised at children's viewing times, while the *recommended* foods are advertised at viewing times intended for women or the general public. Taras *et al*. (1989) claims that, when attempting to persuade their parents to buy them such-and-such a product, children become vehicles for the advertising industry. When their persuasion is successful, therefore, we may say that advertising does indeed influence what children eat. In fact, when they have a bit of money to spend on some food or other, many children, attracted particularly by the advertisements they contain (picture cards, stickers, toys), usually buy these kinds of foods. However, the number of hours children spend in front of the television, what they should eat, or how much money they should have, has more to do with domestic or educational decisions than with the impact of publicity.

The homogenisation of food consumption cannot be explained by the effects of advertising because food advertising is heterogeneous *per se* – as is the supply of food products. It is the standardisation and mechanisation of the production systems on farms and animal farms, the improved transport facilities and the extension of commercial distribution networks to all over the world that are helping to suppress local varieties and, therefore, to bring about homogenisation between regions and suppress some of the differences in the consumption patterns of the social groups within the same geographical and cultural area. This uniformity is partly compensated, however, by the fact that hundreds of products from other countries reach our markets and because the seasonal nature of food products is getting increasingly relative. Moreover, advertisements do not seem to play an important role in the increasing sedentariness of the population, in urban development, in the new conception of time and the pressure of work. This are aspects that really are restricting our dietary behaviour and standardising the dietary behaviour of the groups who share the same post-industrial model of society (Gracia 1996 and 1998).

It is true that advertised products are often similar and that they are advertised in the same way in different regions and in different cultures, but today the wide variety of products we find in the shops indicates more that we can opt for a variety in food consumption than that we can standardise the supply of food. For two decades now, the food industry has tended to diversify its range of products more and more, in a desire to reverse mass production and take into account the social and economic heterogeneity of the populations of industrialised societies. As well as the widely consumed food products, it produces others that are more top-of-the-range, more for the minority market. Consumers whose purchasing power is strong assume the production and transformation costs of these products. This diversification of production coincides with the search for new media support and new advertising messages suitable for each target audience.

Since advertisements promote both *recommended* foods and *not-so-recommended* foods, local products and non-local ones, staple products and delicatessen, and at the same time respond to the interests of both private and public advertisers, it is normal to question the general terms in which their negative effects on health are specified. A different matter is not to realise that advertisements, which are based on cultural illustrations and images of diverse origin (Barthes 1961, King 1980, Fieldhouse 1986), supply contradictory information about nutrition that transmits eclectic ideas which heighten the already widespread dietary cacophony (Fischler 1990: 194-195) and make those in charge of the daily diet sometimes choose the wrong options, health wise, from the range of possibilities available.

Advertisements incorporate everything the consumer finds significant. They adapt their information to suit their prime objective, which is to promote goods and ideas that encourage consumption. Food advertisements therefore use several different arguments e.g. nutrition, aesthetics, hedonism, tradition and identity, and elitism. Of these, the food/health theme, with its related medical/nutritional discourse, is one of the most important (8). The response to this is simple. Although most people's expectations regarding the consumption of food are not limited to questions of health, *nourishment* and *a healthy life* are a desire and a concern in every society. For this reason, and also because of the institutional and social recognition of the biomedical sciences, which runs parallel to the medicalization of the daily diet, the nutritional argument and scientific referents are recurring themes in food advertising (9).

3. Nutritional discourse: between persuasion and cacophony

We must now ask how this discourse is used to attract the attention of the target audience. Creativity in advertising is part of marketing expertise and technical knowledge (Giddens 1991: 18) and works on two parallel levels. Firstly, advertising recreates the synthesis and coexistence that people have made of two different kinds of knowledge (one scientific, the other popular; sometimes contradictory, sometimes complementary) (Menéndez 1982, Goulet 1988, Perdiguero 1992), and highlights the old relationship between science and popular knowledge in food choices, and diet in particular. Secondly, it helps medicine to progressively exert its influence on our daily diet, constantly seeking protection behind doctors and nutrition-based terminology. Here, however, it sends out messages that are either not very informative or are totally uninformative (10); through plays on words and images that are full of connotations, advertisements proclaim supposedly healthy benefits and attributes but at the same time omit other objective data or take them out of context. Advertising deprives some popular beliefs of their meaning but proposes no new ones other than dubious statements that are difficult to accept from the medical point of view.

PUBLI-REPORTAJE

Potitos® Nutribén®
los únicos con aceite de oliva

¿Sabes que los Potitos® Nutribén® son los únicos potitos® hechos con aceite de oliva? Así, ya desde que es un bebé, tu hijo se está beneficiando de todas sus ventajas nutricionales.

Aceite de oliva: fuente de salud

Como sabes, el aceite de oliva es la única fuente de aceite recomendada de la dieta mediterránea*, reconocida como una dieta sana, ya que además de equilibrada es muy beneficiosa para el normal funcionamiento del organismo.

Las ventajas del consumo de aceite de oliva no sólo son por su riqueza en ácido oléico, sino también por sus componentes antioxidantes naturales, combinación que, en nuestra dieta, hace preferir y recomendar sin reserva el uso del aceite de oliva frente a otro tipo de grasas.

Potitos® Nutribén®: los únicos con aceite de oliva

Porque sabemos que sólo quieres dar a tu hijo lo mejor, en los Potitos® Nutribén® sólo utilizamos ingredientes naturales y de máxima calidad, y los combinamos para que el potito® sea equilibrado y adaptado a las necesidades de tu bebé. Si te fijas en el apartado **Ingredientes** de las etiquetas, en Nutribén® sólo utilizamos como aceite-grasa añadida el aceite de oliva, no añadimos otro tipo de aceites vegetales ni grasas animales. Y somos los únicos.

Porque en Nutribén® creemos que tu hijo se debe aprovechar de las ventajas nutricionales del aceite de oliva desde que es un bebé. Te ofrecemos una amplísima gama de variedades de carnes y pescados con verduras, en tres tamaños diferentes según las necesidades de tu bebé.

Además, como especialistas en alimentación infantil, disponemos también de una gama de Potitos® de Inicio para ayudar a tu bebé en el difícil paso del biberón a la cuchara, cubriendo de forma equilibrada sus necesidades nutricionales.

Si puedes elegir... ¿por qué no elegir Potitos® Nutribén®?

To illustrate this let us look at two advertisements for the same product: Nutribénâ from Alter babies foods. One advertisement is taken from the weekly women's magazine *Lecturas* published in June 1992 (11) and the other is from the monthly women's magazine *Mi bebé y yo* that came out in December 1999. Both have all the necessary ingredients of an efficient campaign; they attract the attention of the readers, communicate a message and attempt to persuade with pictures, a title and a text. The two motivating themes are the product's functional attributes and the benefits they bring to a baby's health. The written text is based on an expert's report of the product's attributes, legitimisation through *scientific reasoning* (Emmet 1992, Lupton 1996), and the cultural referents of the target readers (concerns about health, emotional links, and a mother's care). In the second

Enséñale a comer potito a potito.

Con el colesterol controlado

Preocupados por los altos índices de colesterol encontrados en la población escolar, NUTRIBÉN ha realizado largos y costosos estudios científicos para atajar este problema desde la infancia y prevenir su aparición en el futuro.

Los productos naturales utilizados en la elaboración de la Potitos Nutribén están analizados y combinados de tal forma que controlamos su contenido en colesterol. Hemos eliminado los elementos que aportan grasas innecesarias a su dieta como la yema de huevo, la leche completa y la mantequilla. Además, somos los únicos que hemos incorporado el Aceite de Oliva, base de la dieta mediterránea, considerado dietéticamente la grasa más pura y la más adecuada para la salud de tu hijo.

Con las proteínas más ricas

Las proteínas son sustancias cuya función es reparar y construir nuevos tejidos. La introducción de la carne y el pescado en la dieta de tu bebé, es por tanto imprescindible para poder desarrollarse y crecer equilibradamente.

Los Potitos Nutribén de carnes y pescados con verduras, debido a la calidad y cantidad de los mismos, aportan las proporciones adecuadas de las proteínas más ricas para que tu bebé crezca fuerte y sano.

Con la sal justa

El excesivo consumo de sal en la dieta del niño, puede llegar a ser causa de hipertensión arterial, además de una carga excesiva para sus riñones repercutiendo en el equilibrio de su organismo.

Los Potitos Nutribén llevan la cantidad justa de sal gracias a un control riguroso mediante un proceso informático que nos permite mantener en cada Potito el índice de sal adecuado, evitando así posibles futuros trastornos. Posiblemente, tú encontrarás soso un Potito, sin embargo, tu hijo apreciará de esta forma los sabores naturales de los alimentos y educará su paladar a sabores suaves.

Sólo el azúcar necesario

Es conveniente controlar la ingestión de azúcar en la dieta del bebé, ya que, un exceso puede contribuir a la obesidad o ser causa de caries dental en el futuro. Además puede convertirse en un goloso y rechazar otros sabores. Los Potitos Nutribén en sus variedades de Frutas están elaborados con frutas frescas seleccionadas por su calidad, dulzor y punto de maduración, y el nivel de azúcar está equilibrado al paladar y a la salud del bebé. No es recomendable añadir azúcar aunque a ti te resulte poco dulce, ya que los Potitos Nutribén están elaborados pensando en las necesidades del bebé.

Sin gluten

El gluten es una proteína que se encuentra en los cereales principalmente en el trigo, cebada, centeno y avena. Algunos niños presentan intolerancia a esta proteína, causándoles trastornos intestinales.

Por ello los Potitos Nutribén no llevan ninguno de estos cereales y por lo tanto TODOS SON APTOS PARA DIETAS SIN GLUTEN.

SI QUIERES MAYOR INFORMACIÓN SOBRE LOS POTITOS NUTRIBÉN, CONSULTA A TU PEDIATRA O FARMACÉUTICO.

En tu farmacia.

Nutribén

Comida sana.

ALTER

advertisement, emotion-based communication is established by the link between mother and child (the advertisement's target audience): "*Teach him to eat*...", and attention is drawn by the picture of a child – a baby whose face is full of satisfaction as little by little he accepts the food he is offered. Every mother in our culture understands this message; the main reward for providing material care of this kind is a strong and healthy child. The first advertisement establishes communication by creating a complicity between the aims of maternal care, always doing one's best for one's children ("*Because we know you only want to give your children the best*..."), and the aims of Alter's laboratories – and babies' health is assured by marketing products that contain every nutritional advantage. The advertisers attract attention by highlighting a recognised the receivers of their message consume ingredient that they believe: olive oil, as part of the Mediterranean diet. The WHO and Harvard College nutritional pyramid, like the bottle of olive oil and the institutional logo, are, as the title shows, the referents used to differentiate and extol the product: «*Nutribén baby foods: the only ones with olive oil*».

The information in the texts predominantly highlights nutritional aspects:

- *A cause-effect relationship*, which is not always scientifically proven, is described between the consumption of certain products and the onset of certain illnesses (fats = higher cholesterol; too much sugar = obesity and tooth decay; gluten = intestinal disorders).
- Because of their unsuitability, certain foods (egg yolk, full-cream milk, butter, sugar, salt, some vegetable oils and animal fats) are proscribed when they are eliminated from the composition of baby foods.
- Supposedly *natural, high quality* products, like olive oil, meat, fish and fruit, are consistently revered, irrespective of any industrial processes to which they have been submitted. Both advertisements refer to the Mediterranean diet as the healthy diet *par excellence*.
- Some *basic principles of nutrition* (e.g. what are proteins? What do they do? What is gluten?) are mentioned, but only as mini-lessons to justify some of the baby food ingredients.
- *A medical function (prevention and therapy)* is proposed; baby foods prevent illnesses linked to incorrect dietary habits and correct possible irregularities.

Although both advertisements employ the medical-nutritional discourse and have similar styles, there is a marked difference in the role they attribute to the nutritionists, or mothers, in child nutrition. The second advertisement shows the product as the most rational *food* one can give to a child because it prevents incorrect nutritional practices on the part of the mother (supplying too few proteins, adding too much salt and sugar, disguising natural flavours or feeding cereals that are too rich in proteins). The idea is quite clear; what adults believe and what they like best is not always what is best for their children. The discourse behind this advertisement is underlined with a medical report warning mothers of the health problems that their children may be caused by a deficient or over-indulgent diet.

The first advertisement abandons a narrative style that is based on scientific superiority and is almost disparaging of the knowledge and skill of the mother. It places itself on the same level as those in charge of infant nutrition, with whom they converse and whom they inform of Nutribénâ extra advantage – olive oil – in the knowledge that they will know that it is *good*, not just because of its taste or texture, but because of its nutritional value: «*As you know, olive oil is the only recommended source of oil in the*

Mediterranean diet. Its advantages... are not only its high oleic acid content, but also its antioxidant components...». This reinforces a product whose consumption was questioned only a few decades ago by the medical science community, a fact that coincided with the large-scale introduction of sunflower oil into the Spanish market. Moreover, in the first advertisement, which came out seven years after the second one, we can see a further medicalization of the daily diet; mothers, who have more and more criteria for deciding which practices are healthy and which ones are not, can now recognise the nutritional advantages that make them prefer and recommend different foods. Also, processed baby foods are helping children to take that difficult step from the baby's bottle (and why not from the mother's breast?) to the spoon.

In general, the arguments are similar to the explanations a paediatrician gives in his consultancy or a doctor writes in his manuals, or the advice an expert gives in programmes on health. It is true that in the first few months of a child's life, foods like salt, gluten and eggs must be avoided. But how many specialists in nutrition would endorse these advertisements? Probably few of them, or else they would make one or two modifications. The food industry gives priority to medical discourse to introduce products that, if they become a child's only source of energy, hardly provide the required quotas for the balanced diet they speak so much about. The composition of processed baby foods, at least in the range of such foods in this study, lacks variety, and promoting them as the perfect children's diet is irresponsible. One advertisement that, with an ingenious play on words, invites parents to teach their children to eat *potito a potito* (12), promotes radical changes in the traditional *savoir-faire* method (different ways of preparation, weaker tastes and textures, less variety of foods) and, more importantly, encourages the *information-disinformation* process. The pseudoscientific ideas expressed in this advertisement are incomplete and/or out of context. On the other hand, they hardly mention any of the other advantages they may have e.g. convenience, which, at least in our country (13) is suggested by mothers as a justification for using this product. In fact, baby foods are a good solution when the preparation of children's meals is conditioned by the need to save energy or by the shortage of time and resources.

This is just one example from thousands. Imagine the cacophonic effects on nutritional *savoir-faire* of all the advertisements that hope to grab people's attention by seeking protection behind a whole range of different objectives (not only health but also aesthetics, pleasure, identity or social distinction) and to which we must also add all the similarly disparate and changing ideas disseminated by other subjects and channels that enjoy a greater recognition and credibility than advertising – like schools, families or doctors. The difference between an advertisement for an insurance policy and one for instant cocoa recommended by a doctor as a necessity, or between an advertisement for a bank and one for a children's food claiming to be a substitute for something, is that the latter are eaten – they are ingested both materially and symbolically. And, depending on the values and significance that are attributed to them and the place they will eventually have in our diets, their consequences for our health and our knowledge may or may not be recommended. It is on this level that we must first evaluate the probable impact of advertising.

It is in ideological discourse that advertising has a social effect. This is independent of the fact that, as the audience claims, the advertisements may not be believed or may not influence the housewife's shopping – although they may do so via her children. It is also independent of the fact that it may not be the cause of the homogenisation of consumption. This is another debate. How advertising affects food culture can only be understood if we know what it responds to and what it offers – needs and desires, and the satisfaction of these needs and desires, i.e. service. These desires of the population in matters of food, which the industry sometimes takes as a starting point, sometimes as problems that need solving, and sometimes as an excuse, are, according to the industry, satisfied by its products, not only in terms of tastes, but also in terms of practices. Sometimes the industry uses "need" as a starting point for finding the "solution".

Food is advertised in hundreds of ways. More importantly, it is presented as the *solution* to the needs generated by the contemporary food order and as a natural, balanced and healthy diet. But is it really a need? Do babies really *need* to eat convenience foods? The food industry's use of the word "need" in its argument leads to a deeper debate that is not dealt with in this article. In the both advertisements we have analysed, however, one question that is a major contemporary constraint is missing. The real need to gain time in a society in which the pressure of work and the diversity of our activities greatly determine our decisions on food; in which many more women work both at home and outside the home; and in which time spent not working is valued. Feeding *baby foods* to a baby is easy, convenient and quick: you do not have to think, you do not have to shop, and you do not have to cook.

What we must ask ourselves is why this argument is absent from advertisements for baby foods, which are mainly directed at mothers. Advertising uses other, more effective, arguments instead. As these are based on medical and nutritional references, they are more in a position to ease parents' consciences. It does not matter whether their arguments are scientifically sound or not. They just have to seem credible, include at least some of the ideas doctors use, or be recommended in the media or by politicians. They have to present foods as the *solution* for people who are concerned about their family's health. When these products find their way into the pantries and fridge's of people's homes, they are accompanied by this advertisers' discourse and their undoubted practical advantages.

This is the effectiveness of advertising and, ultimately, the justification for people's changing behaviour in matters of food. The paradox arises with products that, although useful, may contradict the leading food model – based on the prudent, balanced diet – because for all the variety the food industry may offer, and however recommendable these products may be for certain occasions, taken together they do not constitute a *balanced* diet for our children. Certainly, advertising must persuade, but it must do so without misinforming, without deliberately omitting any of the products' fundamental properties, and without generating or accentuating misunderstandings or errors that affect the way we prepare and plan our daily diet.

Notes

(1) Many studies of the functions and effects of advertising have echoed this debate that began in the late fifties and has continued, with one or two slight changes, until today. Consult, among others, Leiss, Kline and Sut (1986), Mattelart (1990, 1991), Costa (1992), León (1996) and Fowles (1996).

(2) Most research has attempted to define how advertising affects businesses, the economy and society. It has linked advertising campaigns with business concentration and profits, and highlighted the interaction between advertising and volume of sales. See León (1988) and Aaker and Myers (1991).

(3) Mattelart (1990) says that today we can speak in terms of maximum technicality and minimum efficiency. The higher the exposure index the less is remembered. It is as if the advertisement just washes over consumers. 85% of all advertising messages do not persuade because they have not been seen or heard, while between 5 and 10% of them, although received, are not considered credible.

(4) See also, for example, Ward (1980), Singer (1986), Ward (1986), Anselmino (1987) and Brée (1995).

(5) In the last few years these figures have increased; in 1999 the average number of hours per week spent in front of the television was 35. Although slightly higher, this is not dissimilar to the almost four hours per day that children in Spain spend on average watching television.

(6) These advertisements were approved for March 1991 by the TVE (Televisión Española) Advisory Committee. We chose this month to avoid periods that might be subject to seasonal patterns of consumption.

[7] We have accepted the intrinsic arbitrary nature of this criterion. No foods are absolutely bad or absolutely good for one's health and how suitable or advantageous they are depends, among other factors, on how often they are consumed and how much of them are consumed. Nevertheless, because of their concentration of certain substances, some products are, nutritionally speaking, less recommended.

[8] 40% of a sample of more than 600 advertisements analysed in a previous study (Gracia 1996) used this line of argument.

[9] In fact, the use in Spain of medical- and nutritional-based terminology in advertising dates back at least to the origins of modern advertising. Its use is historical; the first advertisements in the gazettes of the XVII century already established a link between medicine, health and certain foods (Sánchez Guzmán 1982).

[10] Leets and Driggers (1990) call this type of advertising, which is based on decorative and not very objective features of the product, puffery or superficial.

[11] This advertisement was anlaysed in greater detail in a previous study (Gracia 1993).

[12] In Spanish these words are similar, phonetically, to the expression poquito a poquito (little by little).

[13] The volume of sales of baby foods in Spain is lower than in France or Germany. Here, 20 kg per child is consumed, while in France the figure is as high as 85 kg.

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RELIGION

AM
Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 143-144

Medicine and religion

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> "L'alternativa fra 'magia' e 'razionalità' è uno dei grandi temi da cui è nata la civiltà moderna"
>
> Ernesto de Martino 1957

Sud e magia

Any review of the history of anthropology can establish two facts. The first is that the prominence of investigations into religion in our discipline is associated with a historical boundary between science and belief that is at the origin of our knowledge and practice. For a considerable time, religion was the paradigm of the world of the irrational, belief, mysticism and otherness; a *pensée savage* logic – or lack of logic, depending on the point of view – that the anthropologist had to decipher using deductive formulae or clever ethnographic abductions. The second is that the prominence of the issue of otherness and irrationality, which classic investigations into religion staged so well, largely prevented anthropology from recognising indigenous medicines as local sets of knowledge and practices. Classic works like Tylor's *Primitive Culture* or Frazer's *The Golden Bough*, both full of references to native therapeutics, absorb the medical phenomenon within more urgent issues for their age such as religion, the world of "primitive" beliefs and, in short, the enigmatic landscape of cultural otherness.

Probably one of the texts that best portrays this problematical relationship between religion and medicine and, at the same time, restores some sort of order is *Witchcraft, Oracles and Magic among the Azande* by Evans-Pritchard. Partly because the ethnographic approach helps to dissolve some prejudices about the ways of thinking of other cultural worlds, and partly because of his theoretical skill, he suggests to us that empirical logic is not unknown to the Azande. Curiously, his strategy not only brings us closer to, and makes us more familiar with, the culture of the informants but also maintains the rationality of scientific thought. He simply uses two questions to order the worlds of belief and science: a mystical “why” and an empirical “how”. The latter question recognises the native as a pragmatic social actor, who Malinowski had attempted to represent in his monographies several years before, and as a subject who is capable of ordering and interpreting reality from facts that are expressed in causes and effects. The former, however, appeals to the social and existential sphere of human misfortune which, although it does not contradict empirical knowledge of cause and effect, does make it complete by providing a set of values and meanings. Now, does not the cohabitation of facts and values always involve some degree of mutual contamination or fertilisation, depending on how you look at it? In addition, no less important, does the very identity of medical anthropology depend on discovering the values behind the facts, whether they are shamanic or biomedical, and at the same time showing their materiality and pragmaticity? Despite their diversity, the texts in this section speak to us of how facts and values contaminate each other and how anthropologists can account for this intricate relationship.

AM
Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 145-165

Medieval hagiographic sources and Medical Anthropology.

Thaumaturgic saintliness as a cultural device in the defence of health in 12th-14th centuries Orvieto

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From the hagiographer to the ethnographer

Thanks to its socio-cultural implications, the phenomenon of saintliness within the Catholic culture has always been, and still is, a permanent subject of attention and controversy. Existential endorsement and rational condemnation, participative acts of faith and sceptical intellectual denouncements, ritual devotional behaviour and scathing polemics alternate and interact to form the "fame" of the saint in a joint production which reflects complex social dynamics.

In a lay perspective, the attempts of historiographical and sociological disciplines to interpret saintliness have brought to the fore the relevance and complexity of a phenomenon all too frequently brushed off as naive beliefs of bygone days. In this context, medical anthropology can contribute to the endeavours to conceptualise saintliness by defining the characteristics of the component of the phenomenon.

It should be noted that the fundamental correspondence of saint and thaumaturge goes beyond the limits of time and space dealt with in this paper. Indeed, for the Mediterranean countries and the Early Middle Ages the *presentia* of the saints is instrumental in the affirmation of Christianity, whose relationship with local religious cultures can be synthesised as a «conflict of therapeutic models» (Brown, 1983 [1981]: 164). Moreover in its strategy of Christianising the culture of the popular levels of medieval society, the Church has alternately aimed at obliterating cultural patterns and creating thaumaturgic figures (Cardini, 1989). In the pre-industrial society of the Early Middle Ages, the saint as thaumaturge is an essential figure who guarantees both a social pervasiveness and recurrent occasions for reaffirmation to the authorities. The broad range of semantics concerning *infirmitas* and the correlated conditions in which the crowd of *pauperes*, *egroti* and *languentes* find themselves may serve as an example. It must also be kept in mind that since there were no strict rules regarding the segregation of the sick into specific places devoted to their care and that secular therapeutic practices were weakly structured, the presence of the sick in the social spaces of the community – piazzas/fairs, churches/ceremonies, streets/pilgrimages – was a daily and almost obsessive occurrence (Agrimi; Crisciani, 1993).

The motivation for these historical facts can be found in the anthropology of power. Power must necessarily attempt to dictate representations of its own of health/sickness. This binomen reproposes the cultural "core" of the unstable relationship between biological and social and between nature and culture (Seppili, 1994) and lies at the root of all the connotative extensions that can be schematically traced back to the polarity of positive and negative. The hagiographic text, which lays particular stress on the curing of the illness – either by the direct action of the saint, or as the effect of a ritual act on the part of the faithful – succeeds in capturing and expressing a symbolically "nuclear" aspect of the culture, which produces it. The saint, already an efficacious "monumental" representation of power, constitutes an ideal charismatic protection and serves as catalyst for the attempts to find an underlying reason for the disease, "elementary form of the occurrence" (Augé, 1986 [1983]). This then strengthens the institutional patterns of society because they resist the biological disorder, perceived always as a threat to the social order.

The fabrique des saints

Pietro Parenzo, a figure in whom the political virtues and the noble spirit of charity are brought together, was a prominent member of a family of administrators of the state, active in central Italy in the Late Middle Ages and whose origins go back to the Roman patriciate. According to his *Passio*, an important document in ecclesiastic antiheretic polemics, Pietro Parenzo arrived in Orvieto in February 1199, sent by Innocent III who answered a petition for a delegation of the city. On May 20th he was kidnapped and assassinated by Cathar conspirators. In subsequent actions of retaliation, the identity of the group broadened to include all those who opposed ecclesiastic policies. On a local level, the feast of Pietro Parenzo was quickly recognised and appears in an act of submission to the *Comune* as a date on which a candle of twenty *libbre* is to be offered to the *Chiesa Maggiore*. His canonisation, on the other hand, was never to be recognised, coming up against the strict canonisation regulations established by Innocent III (Vauchez, 1989 [1981]). The last initiative for the canonical acknowledgement of Pietro Parenzo was decidedly secular with regards to the figure who made the request, and political with regards to the underlying objectives. This, however, makes it all the more significant. The attempt was made in 1932, over seven hundred years after his death, by the *Podestà* of Orvieto, Pericle Perali. In a pamphlet dedicated to the Head of State, His Excellency Benito Mussolini, the local authorities once more turned to the central authority in an attempt to elect Pietro Parenzo, called saint, as protector of the Italian *Podestàs* (Perali, n.d. [1932?]).

From June 12, 1240, to February 16, 1241, Rainerio the Bishop of Orvieto; Gualcherino the Bishop of Soana and Citizen and Augustinian prior of San Giovanni in Platea, investigated the miracles attributed to the Franciscan thaumaturge Ambrogio da Massa. The notary Rainerio drew up the acts of the trial, which contained 209 testimonies regarding 83 miraculous healings. Pope Gregory IX authorised the investigation in a letter of May 24, 1240. He confirmed that he had received the petition for canonisation presented to him by the Council and People of Orvieto (*Processus*). The petition addressed by the Commune to the Pope gives us an idea of how intimately intertwined the relationship between this civic institution and the Franciscan friars must have been. The mid-13th century decades witnessed the setting up of the headquarters of the friars in the city. Their church was consecrated in 1266. The Pope's letter granting the institution of the investigating Committee bears witness to the assumption of exclusive *potestà* by the Roman Curia in the discipline of canonisation (Goodich, 1975). The *Processus* of Ambrogio da Massa, a document of an investigative situation which in other cases has been defined as "proto-ethnographic" (Burke, 1979), removes the friar from anonymity only with regards to his entrance into the Franciscan Order. It testifies to the friar's ascetic life style; i.e. mortification of the body through exposure to the inclemency of weather, the exercise of restrictions in food, etc. Convent cook and physician, Ambrogio da Massa possessed surgical skills of an empirical nature, and applied sutures and bandages of wax or tallow.

Giacomo Scalza, a contemporary of Vanna da Orvieto of whom he was the Dominican hagiographer, is an example of a male figure who, first, counsels spiritual itinerary and subsequently constructs the literary identity of a saint (*Legenda*). This was common practice in the history of the women connected to the mendicant Orders and obviously raises questions as to how the prevalently female mystical experience is translated into the hagiographic text (Coakley, 1991a and 1991b). *Contemptus mundi* and defence of virginity are combined with the usual ascetic practices of fasting, vigils and meditation, which become frequent once the habit has been donned. These experiences of "real mysticism" lend themselves to multiple interpretations, which can, on the one hand, be related to forms of mystic nuptials. On the other hand, immobility, exposure to the inclemency of the weather and sweating can be an exercise in "body techniques". Mental processes of meditation and "body techniques" produce states of consciousness through which Vanna da Orvieto moved into the ecstatic repertory of catatonics, of stiffening of the body and levitation. The only non "legendary" document regarding Vanna is the resolution of the *Consiglio dei Sette Consoli delle Arti* dated May 7, 1307, regarding the offering of a candle. The day on which the office for Vanna is celebrated, a candle of twenty *libbre* is taken to the Dominican church, where the Podestà, the Capitano del Popolo and the Sette Consoli bury the Blessed Vanna. Vanna, the church of the Dominicans, receives a significant hommage. The weight of the wax offering is one of the highest, second only to that which the civic institution offers the Cathedral church.

In the summary descriptions given above of Pietro Parenzo, Ambrogio da Massa and Vanna da Orvieto, these figures have nothing in common. The biographies on which the construction of their sainthood is grafted are diverse, as is the historical period in which each of them lived their earthly lives. Different, and identifiable, are the interests of the social groups which motivate the construction of the saint and the forms of hagiographic writing which constitute testimony and documentation of the earthly activities of each of the three are also different.

A historical-anthropological approach to saintliness cannot but see it in the light of a social phenomenon concretely bound to a historical situation. The focal point of reflection on saintliness is defined by the study of the continuous fluctuation between the unique characteristics of a subject considered saint, and the ways in which the community, or its hegemonic social classes, construct the mental and practical reasons, which makes it credible. This is the *fabrique des saints* (Schmitt, 1984), in the understanding of which the conceptual equipment of philology, history, sociology and anthropology concur, and it, therefore, becomes a relevant object of study. As Pietro Parenzo, Ambrogio da Massa and Vanna da Orvieto are concerned the *fabrique des saints* shows us how types of saintliness reflect the lines of modification of social leadership. The case of Orvieto confirms the transition, which in the history of saintliness accompanies the passage from the Early to the Late Middle Ages, from a remote exemplarity referred to hierarchic institutions of sacred regality to a humanisation of people close to the emerging social and urban classes (Vauchez, 1989 [1981]). The case of Orvieto is also the empirical confirmation of how the stories of the saints constitute a privileged observatory from which the dynamics of the social relationships within the society can be reconstructed. They reflect the organisational and value system of the society in which they are defined (Boesch and Sebastiani (eds.), 1984; *Ecole Française de Rome* and *Università di Roma "La Sapienza"*, 1991; Golinelli, 1991).

The methodological option, which derives from the considerations above, allows us to force a philological individualising interpretation of the texts we have chosen in order to compose them into a unified hagiographic corpus. A *Passio*, a *Legenda*, and a *Processus* for canonisation have, obviously, prerogatives of compositional structure and a stylistic-formal nature, which are peculiar to the types of hagiographic writing to which they can be referred. The analysis integrated on the level of content, by the three narration-documents makes them mutually subsidiary to each other. It increases the amount of information provided by the texts and makes the interpretative itineraries much richer (Boesch, 1982). The selected hagiographic corpus thus seems to form a series of comparative contexts which can be traced back, as far as the problems connected with the defence of health and of the individual and collective psychic equilibrium are concerned, to a common cognitive, emotive, behavioural and practical paradigm. The *Passio* of Pietro Parenzo, the *Processus* of Ambrogio da Massa and the *Legenda* of Vanna da Orvieto appear as particular conjugations of this paradigm.

The saint as agent of re-connotation of the civic cosmos

The first element in the characterisation of the saint – with a view to qualifying him as charismatic operator and axiological agent – is his capacity to re-connotate or redefine a civic cosmos. Through the events in his life and his presence, including the future management of his body as source of relics, the saint re-semantises the spaces and times of society. These are the structural supports of a collective cosmology as well as the forms required for all possible experiences on an individual level. Sacralized calendars and topographies draw their origins from the saint and, used ritually, they are presented as concrete itineraries of the exteriorisation of experiences and of the introjection of orthodox values and norms.

In the case of Pietro Parenzo, the reasons and the forms of the *elevatio corporis* are associated with his rank as ruler of the traditional *battagliolae* of Carnival. The controversies in the city as to where the saint is to be buried reflect the social equilibriums and perceptions of civic spaces. The body of the saint is removed from San Andrea, the church of the *Comune*, and transferred to San Costanzo's church, near the Bishop's palace, which is perceived as sacred because it probably communicated with an Etruscan necropolis and where the new cathedral was then to rise. The archaeological fact can be correlated to a line of reasoning which, thanks to morphological comparisons, might be used to illustrate the continuity and contiguity of the cultural patterns from Etruscan and Roman antiquity to the Early Middle Ages, up to the beginning of the 12th century when the terrestrial and hagiographic story of Pietro Parenzo takes place. Keeping at arm's length any evolutionary reductionism and conjecturally overcoming the limits which derive from the absence of documentary data, we can indicate a few cultural "agglutinations": limping, head covered with animal skins, reference to the world of the hereafter, *Caeculus, Hades*, seasonal cycle, Carnival, which seem to form at least a part of the "symbolic capital" from which the canon Giovanni draws when he writes the *Passio* of Pietro Parenzo. There is no reason why we cannot suppose that this body of contents is organized on various levels of awareness in relation both to the acculturational modes through which it is acquired, and the occurrences of its sedimentation, which in any case is common to the collective mentality.

The *Passio* of Pietro Parenzo also furnishes the particular elements that allow to reconstruct the phases of the progressive connection between this martyr and the entire urban space of Orvieto as opposed to the wilderness, the receptacle of the dregs of humanity, the hut, which express a negative elsewhere, physically *extra civitatem*, cognitively *extra communitatem*, which only the saint, a liminal figure, can dominate. The body of Pietro Parenzo adheres to the ground and it is impossible to raise it. It closes its mouth so that the conspirators are unable to throw in the saint's remains. A dead walnut tree comes back to life on contact with the body. Pietro Parenzo can be considered *munitor urbis* in all those cases where a society is threatened or feels it to be threatened materially and spiritually by heresy.

A more adequate exhibition of the body of the Blessed Vanna, who will have a "double burial", and the resulting increased publicity, are the symbolic correlation and the ideological justification for an actual settlement.

In using the remains of the local saint to set in motion a line of communication that can leave its mark on the re-connotation of the significance of the sites, the preacher friars reveal their awareness of the different levels of the 13th Century Orvieto community and their desire to permeate these levels. The complex of *San Domenico* is at the edge of the city, near *Porta Vivaria*. Beyond it the *Campo degli Omodei*, the unconstructed part of the city, stretches. It stands on a site where there was once a temple and it has to deal with a negative fame deriving from the fact that the environs were the habitual haunts of procurers and prostitutes.

Referring to the north-south axis, on the other side of the city, in the district of Serancia, near *Porta Pertusa* and diametrically opposite *Porta Vivaria*, is the church of the Friars and the *Processus* of Ambrogio da Massa shows us how important, in this case too, was the association of the local saint with the mendicant church, built or under construction, which, according to the testimony of his followers, was to bear his name.

The intertwining of similarities between the construction yards – which define the urban physiognomy of Orvieto in the 13th century – and the "making of the saint" through which, officially, the cultural identity is constructed, is particularly strong. Patterns of civic settlement, natural restrictions that depend on the nature of the tufa mass on which Orvieto stands and the system of values of a community interact. The bodies of the saints, placed in sepulchres, which permit ritual action, shape the city, which thus finds a meaning for its projections in space. The liminality of the saint and the location of the churches at the edge of the city are aspects that are consonant with a collective mentality, which takes a stand against a morphological-environmental diversity in an endeavour to reinforce its processes of defining its identity. This is taken up and formalized in the procession of *Corpus Domini* «sanctifying circumambulation of the urban agglomerate» (Dupront, 1993 [1987]: 538). The route of the *Corpus Christi* procession, established in Orvieto by Ermanno and his brother Beltramo Monaldeschi – Lord the former and Bishop the latter of Orvieto – in 1337, includes the churches which we have mentioned as sepulchres for the local saints.

Homo homini salus

The ethnography of the connections between civic sites and bodies of saints has revealed one of the perspectives used by hagiographic writing in its attempt to collocate the saint pervasively as an agent of re-connotation of the civic cosmos. Ethnography applied to the anatomy and physiology of the holy bodies as revealed in the rhetorical strategy employed provides us with another essential aspect that throws light on the specific meaning of these bodies, the value attributed to them and how they interconnect with the civic spaces.

Through olfactory, visual and tactile metonymies, the *Passio* of Pietro Parenzo expresses the "vitality" of the corpse, the object of the attention of the religious of the Chapter of San Costanzo and their following. The significance of the post-mortem incorruptibility of the body of Pietro Parenzo is stressed, by contrast, in the chronicle of his martyrdom, brutal crime, which dramatically describes the blows dealt by the heretics, the wounds inflicted, the fury unleashed against the lifeless body, the final scalping. The *Passio* lets us reconstruct the associative chain that has its origins in the body of Pietro Parenzo: the aromatic corpse, the sepulchre of healing, and the elevation of the site of burial to a point of arrival for itineraries in which the community finds a common identity. In this case, too, by contrast – almost the result of a basic logical symmetry – the significance is stressed. A damned corpse is associated with the swelling of the body, the foetid miasmas that it emanates, the diseases and disasters it provokes, and lastly the contaminated and dangerous places of the *damnatio memoriae*.

The use of the olfactory canal in the corporeal code of determining saintliness, composed on an official level in a "doctrine of aromas" (Albert, 1990), continues, in the various social strata, throughout the Christian Middle Ages. It is obvious that in testifying to the saintliness of their local figures, Ambrogio da Massa and Vanna da Orvieto, one of the arguments used by the respective hagiographers of the mendicant Orders was that of the "divine fragrances" emanated by the corpses. In particular, the *traslatio corporis* of Vanna da Orvieto relates the appearance of balsamic oils, to sprinkle and inundate, and a prodigious manna covering the body. These are additional elements that serve to qualify the prodigious impassibility of the holy corpse, which appears as an instrument of collective health. The mutilated body of the martyr and the holy liquors of the virgin both broaden the spectrum of efficacy of a sacred pharmacopoeia, which is the religious transposition of the profane *homo homini salus*.

The *Legendae* of the saints are concrete examples of a strategy of charismatic accreditation of the salvation prerogatives of the institution, which produces them. By means of an allegorical text, which transposes them on a symbolic level, they succeed in reconciling the demands of an institutionally constituted power with medical practices of remote and diffused origins, which use parts, excrement, and body exudations in preparing curative remedies. These practices are so deeply rooted that up until recently, doctors and charlatans sought the raw materials they needed to prepare their medications in cemeteries or in an ambiguous trade with hangmen, torturers or simple barbers (Camporesi, 1980 and 1983).

Clinical hagiography and construction of the disease

The *Processus* of Ambrogio da Massa allows us to verify the relevance of the considerations developed by medical anthropology, beginning with the identification of the disease as an "elementary form of the occurrence" and the concept that the individual diseased body functions as a "social signifier". It also gives us insights into the ways in which hagiographic writing organizes bi-directional passages of meaning from the biological order of the corporeal occurrences, to the social order of moral and religious occurrences and how construction of the representation of the disease is determined in the concrete play of cross-references between the two.

If we adopt a hermeneutic mindset which reconciles the methodological circumspection imposed by the nature of the records (a notary document of a clerical investigation) with an attention to the risks, which a historiographical operation "based on an a priori hypothesis" almost inevitably entails. We seem to have at our disposal a significant sampling to help us reconstruct the attitudes and cultural strategies adopted by the community in the process of determination and interpretation of the disease. The *Processus* of Ambrogio da Massa is therefore representative of the pattern of disease in 14th Century Orvieto, with all due recognition of the fact that as a cultural product, the filter of the "hagiographic *langue*" acts as censure in the service of power tactics. It is a document of considerable cultural complexity.

Generally speaking, comparison of the disease to a kind of performance is not a generic metaphorisation, but a precise form of the relationship that the community establishes with the disease. In a body that is diseased, and which is therefore of social significance, the disease itself is acted out for the benefit of a public, which reacts as a social body. Moreover, the disease is therefore no longer an abstract notion but a concrete representation. Spectators (p. 12) of the drama acted out through the body of a sick person are the relatives, but also all those in the neighbourhood who participate in the pressing demands of the "inquisitors" and who fill the house at all hours of the day and night. The members of the commission themselves are morbidly interested, *ex post*, in the search of a sign on the body.

The pathological is expressed and perceived thanks to the fact that the horrible is turned into a spectacle, monstrously dramatized as one-deposition follows the other. For the family, mostly women – incidentally, the woman continues to be the statistically dominant figure, in the two versions of mother and wife, in taking care of the sick person – the gravity of the perturbation caused by the pathological aggression of what is considered the normal disposition of the body is expressed by the horrible sight. The sensation of risk to which they are subjected by this eruption into society of a biological degeneration is what is burned into the consciousness of neighbours and acquaintances as they participate in a performance, which could potentially include their own persons. The sick body is a breach in the dam which society has built to defend it from the horrible. The horrible that can contaminate society is inscribed and put on stage in the sick body, but since the diseased body is the visible aspect of the social symbol it also, transitively, exposes the entire community to the risk of a regression into the horrible. Actors and spectators of the drama of the disease initially find a reason for falling prey to the disease. On this basis, the performance of the ritual therapy will take place, in the continuous intertwining of roles and reciprocities.

The *Processus* of Ambrogio da Massa permits the identification of a phenomenology of the horrible constructed around pain and its perception. The pain can be so intense that it feels as if parts of the body are being detached, rebelling against the organism. This corporeal dimension of the expression of pain immediately connects to the social aspect of the individual through the faculty of speech. This can, in turn, be compromised by incoherent shrieking or, to the contrary, by mutism to which pain, incorporated in an inextricable tangle of the biological and the social, leads.

The nosological gallery, which the Processus of Ambrogio da Massa permits us to reconstruct, can be considered a representation of degeneration of the human via the loss of the control and exercise of the "social regulations" governing the body and language. The disease, subversion of the normal order of things brought about by the irruption of the biological imponderable, condemns the individual to marginalisation, which he experiences publicly and which is publicly perceived by the community. In overriding perception, the normal attitudes and behaviour of the body and the use of language, the disease is the occasion and site of the alienation of the individual.

From the clinical medical point of view adopted by hagiography, the horrible nature of the disease appears in relation to diseases of the osteo-muscular apparatus and the integument system. This is shown by the frequent occurrences of those with "contractions" and those afflicted by "abscesses" in the lists of those imploring the thaumaturgic intervention of Ambrogio da Massa. The pathological degenerations of anatomical-physiological characteristics furnish the categories – and are interpreted via the categories – of the dry, the rigid and the arid, to which those of the rotten and the putrid are contrasted. The legion of paralytics, arthritics, cripples and the barren show the various phases of degeneration at the larval state, of the monstrous deformation, of the leanness which also concerns the *vis generandi.* Significantly the disease seen as the drying up of the entire body around deformed skeletons producing arid larvae, has its counterpart in the disease seen as an exuberant decomposition of the organic, which produces festering liquids and miasmas of putrefaction. Abscesses, ulcers, fistulas, emphysemas, cysts, phlegm, which erupt in serous emissions and secrete haematic suppurations and with purulent sores, coloured by the rotting decomposition of the organism are examples. The nose replaces the eyes in defining of the senses of abnormality and the disease is recognised by its stench.

Cultural strategies and ideological tactics are ranged around the disease and pain. The *Processus* lets us reconstruct the area of significance of the *laborare* of the *infirmitas*. In addition to *laborare*, whose semantic area includes suffering and being in danger, the verbs used to express the action of the sick person are: *occupare*, which means taking over, surprising; *tenere*, which means holding, occupying, surprising; *tangere*, which means striking, hitting, but also for violating; *adripere*, which means grasping, dragging, assaulting; *torquere*, which means twisting, bending, tormenting, torturing, afflicting; *vexare*, which means upsetting, mistreating, devastating, harassing, tormenting.

In the continuous intertwining of the denotative and connotative levels involved in the description-interpretation of the disease, two guiding principles of meaning can be identified. The first refers the disease to animality. The disease attacks like an animal and lacerates the body. In consideration of the characteristics that the disease assumes in the context of community, what we have here is a polar contraposition between the binary opposition humanity-health and animality-disease.

The second guiding principle refers to the demoniac and sacral for the disease. In this case, due to the acute perception of the core significance of the disease, an ideological design for subduing the disease comes to the fore, in which the forms of power are expressed, in relation to the administration of the charismatic virtues of the thaumaturge.

The continuous overlapping of denotation and connotation, of description and interpretation to which medical-hagiographic clinical medicine is reduced makes it impossible to trace a clear line between the first and second guidelines of significance, between the bestial and the demonical-sacral components of the disease. In any case, the representation of the *morbo caduco* can be taken as the keystone of this process of constructing the meaning of the disease, giving a name and form to the biologically horrible through the symbols of animal degradation and demonic possession. To suffer from the *morbo caduco* means to appear possessed. The symptoms of epilepsy, above all the sudden falling to the ground described by listing the number of times it happens by day and by night, but also convulsions and the emission of saliva, are the corporeal signs of possession which can be resolved only near the saint's sepulchre. Possession by the demon corresponds, almost for the necessity of symmetry, to the *morbo caduco*, the disease of the body described by a demonic-sacral semiotics of possession. The manifestation of possession by the demon is described as an oppressive syndrome, which cannot be contained. Its solution, after exorcism, is proved by the disappearance of all corporeal signs.

However, it is in the "anamnesis" phase that the construction of the disease can be more easily referred to an ideological horizon, taking into account the importance that the administration of the charismatic treatment of questions concerning health/disease in a community assumes. In the same way it is also aware of the possibility that this administration offers for the strengthening of a power that has been concretely defined and is searching for symbolic strategies of legitimisation. It is when the hagiographic document moves on to treat what we might call interventions of retaliation on the part of the saint that the ideological administration of the charismatic operator of health comes most strongly to the fore. Generally, blasphemy is what gives rise to a circuit of transformation so that, through the susceptibility of the saint, which becomes a precise etiological factor, a verbal offence directed at the saint becomes a somatic offence, which strikes the blasphemer. A linguistic act, which expresses an intellectual and ideological deviance, is thus impressed in the body of an individual. Since the body is endowed with social significance, it is interpreted as a stigma for the entire community and the Orvieto hagiographic corpus proposes a considerable range of results of the breaking of the linguistic taboo, which surrounds the name of the saint.

The identification and demonstration of the thaumaturge saint: body techniques and oneirism

The thaumaturge saint is allotted a specific role in the construction of the representation of the disease and a specific function in the pervasive occupation of symbolic spaces by power. This role and function must be given a precise place in the social agencies or groups where the culture that gives meaning to the experience of disease circulates and takes shape. What we have here is a real system. What characterizes this system, which is at the same time identification and demonstration of the thaumaturge saint, is the use of two codes of expression. One organizes the ensemble of somatic signals, which are assigned to the body of the saint; the other organizes the body of signals, which comes from the oneiric states of consciousness. On the one hand, it is the quality of the thaumaturge saint's biography that serves to indicate charismatic virtues, depicting him as a figure that mortifies his biological component and uses body techniques to overcome what is considered the normal anatomic-physiological state of man. On the other hand, the body of oneiric manifestations consisting of vision-dreams, which revolve around the figure of the thaumaturge saint, are what furnish credible origins to the rite and the cult that will develop.

For Pietro Parenzo, the *Passio* proposes a picture of eminently political personal virtues and intimates a genealogical relationship of his social rank with the charisma of the thaumaturge. In one sense the *Processus* of Ambrogio da Massa and the *Legenda* of Vanna da Orvieto are presented as a "comparison", shown by the radical change in the social typology of the saint introduced by the pedagogical and pastoral activities of the mendicant Orders. In both texts, indeed, one finds what has been called the "hagiographic staging" of the biographical aspects of a saint, who is no longer, an aristocrat but belongs to the bourgeoisie (Vauchez, 1989 [1981]).

The obedience of Ambrogio da Massa overcomes the physical and physiological bonds of the alternation of the day-night cycles, of atmospheric adversities and biological needs. The *Officio* of the Virgin is recited *per viam pubblicam*, along a civic and community space. Ambrogio da Massa's falling to his knees is a typical ritual behaviour chosen by the ceremonial gesture expressiveness of the Christian West to reinforce the value of prayer through the use of the position habitually adopted by the entire body (Dupront, 1993 [1987]). However, what is most striking is Ambrogio da Massa's nakedness. This finds appropriate references in addition to the mendicant precepts, which muster, and contextualise the ascetic adage "*Nudus nudum Christum sequi*". Exposure to cold, the significance of which is emphasized by the adoption of ritual denuding, complete or partial, belongs to that logic of mortification of the body which induces particular states of consciousness that reinforce spiritual meditation and prayer. The overall picture attributed by the *Processus* to Ambrogio da Massa can then be seen in terms of an ascetic complex characterized by abstinence, fasting and vigils and by testing resistance to physical pain.

The *Legenda* of Vanna da Orvieto documents the persistence of the complex of behavioural practices that form an "ascetic whole". At the same time it shows us how ascetic practices as a whole are geared to that "syndrome of real mysticism" which emerged, above all from the 12th century on, and which deals specifically with female religiosity. Vigils, fasting and abstinence are connected, in the experience of Vanna da Orvieto, to trances, ecstasy, levitation, catatonia and catalexis to form an actual ascetic-ecstatic syndrome. Nudity and transcendence, which are a condition of the body and a level of reality different from the habitual and contingent to it, are still interconnected. This allows us to believe that they both belong to cultural ambits of bodily representation that are much broader than those codified by the mendicant precepts. The bodies of the saints, as is clear from the treatment reserved for their corpses, are social bodies on which the worshippers exercise a sort of anatomical voyeurism, searching for meanings that can be interpreted in a community sense. The nudity of the holy bodies is then a socially relevant aspect of the saints. It is a social nudity. The valences and ambivalence of other social nudities such as, for example, prostitutes, heretics and the condemned, converge around this social nudity. In the *Legenda,* we have a description of the catatonic state induced by prayer, but we have no indication of the way in which the entourage or the worshippers demonstrate the actual insensibility of the saint during this cataleptic trance. In many hagiographic texts a great deal of attention, however, is paid to the kinds of "stimulation" to which the body of the saint is subjected. This has led to comparisons with pornography in the ingenious morbidity of the *experimenta* (Bornestein, 1995). Catalexis is described in terms of death, and the resolution of the altered state of consciousness and bodily insensibility is interpreted in terms of a resurrection to life. The saint thus becomes the cultural intermediary capable of subduing death, both in relation to defined structural, economic and social characteristics, and to the existential needs of a community.

In addition to the code, that systemically group together somatic signs, the identification-ostension device of the thaumaturge saint makes use of a code, that includes the oneiric signs of dreams and visions. Analysis of the vision-dreams, which appear in the hagiographic corpus of Orvieto, identifies both a general picture of functional references and a specific formative quality in the oneiric state and the oneiric forms of experience. With regards to the former, the dream or vision serves to manifest saintliness and indicate the mode of worship; with regards to the latter, the dream, the vision and their oneiric container, the *incubatio* with the relative practices, directly or indirectly produce thaumaturgic effects.

Dreams, visions or, more generally, oneiric states of experience systematically appear in the *Passio* to lay the foundations for the cult and the rite, to resolve existential states of crisis and to accompany practices of devout rituality with therapeutic effects. The *Processus* of Ambrogio da Massa is an example of how much care hagiographic writing takes to place every episode in a context of plausibility which is determined by a socially defined situation of marginality (for example, wandering *extra moenia* or the personal matters of a dying person). Contemplation and prayer, two aspects of a complex performance, which formalize the syndrome of real mysticism, are presented by the *Legenda* as a condition for the manifestation of the prophetic spirit of Vanna da Orvieto. In all cases, dream and vision are connected to the founding of the cult and rite. This is why interpreters who are the protagonists of oneiric experience and its promulgation are needed. The dream and the vision are then nothing but an organically structured cultural device in the service of that complex of needs and expectations, which in the realm of health/disease turns to forms of ritual medicine and sacred therapy.

The ritual performance

In the range of rites, which refer to saintliness and regard the charismatic treatment of biopsychic discomfort, the hagiographic corpus of Orvieto herewith analysed reveals an inextricable confusion of roles in this field. A comparison with the theatre lends itself also to a ritual situation and the two groups involved can be defined as operators and as spectators of the rite (Schechner, 1984). Strictly speaking, we shall see that, in view of this confusion of roles, the validity of this distinction between actors and spectators depends on ascertaining that the dynamics of the ritual performance have succeeded in overcoming this distinction.

In this sense, it can be noted that, in most cases, it is the sick person himself who turns into the operator of the ritual. In the application of sacred therapy on oneself, the qualification of ritual operator derives from that of sick person. When he is in a condition of inferiority, (physical, deriving from the disease; jurisdictional and social, since he is a child) the ritual relevancy – in the form of expanding concentric circles – includes the entire system of tutelage, relationally immediate or remote, which refers directly or indirectly to the sick subject.

Most often, it is a relative, from the immediate family, who becomes the key figure in the acting out of the ritual. Collective ritual undertakings also are documented in which the role is assumed by the relational network of the extended family, the quarter and the regions of the city, associations whose members have the same profession, representing hamlets and bordering towns and it is they who put into effect a collective performance of a vow or pilgrimage or burial rites.

Together with the lack of discrimination or confusion between operator and spectator of the rite, the *Passio* of Pietro Parenzo, the *Processus* of Ambrogio da Massa and the *Legenda* of Vanna da Orvieto present another confusion, that of the sacred and profane. Above and beyond the rhetorical confrontations, which emerge between prototypes of sacred and of profane therapy offered by hagiography, it is possible to identify a continuous mutual overlapping of knowledge and practices from one field to the other. The ritual, for instance, seems to have no difficulty in accepting the results of medical empiricism, which in turn unhesitatingly makes use of forms of sacred therapy. For example, the midwives who surround a woman in childbirth have at their command a real "multiple medical competence". The body of knowledge in their possession regarding the interpretation of questions concerning health and disease enables them to operate both empirically and ritually in treating their patient. In a difficult childbirth they remove a dead foetus and certify the death by means of an empirical procedure. Subsequently they become ritual operators in the invocatory act meant to bring the infant back to life, up to his baptism. Applying medication or making a votive offering in wax are both aspects of the same type of handwork, a concrete manual skill, of a materiality of action which moves with ease from the domain of the sacred to that of the profane and back again.

The hagiographic corpus of Orvieto permits dreams and visions to be reconstructed as performance in the ritual of healing. In particular it permits the reconstruction of the general conditions, to which the oneiric experience leads, of the effects procured, directly or indirectly, immediately or extended in time, of the forms through which the oneiric experience is translated into the thaumaturgic ritual.

Sleeping and dreaming are connected both with the perception of the sacred and with ritual. In the *Legenda* of Vanna da Orvieto, a vow and the act of appending the relics are effectual during the sleep of the one who makes the vow. In the *Passio* of Pietro Parenzo, the pilgrimage and the vow before the sepulchre induce a thaumaturgic sleep, which completes a ritual clearly related to the classical *incubatio*. In the *Processus* of Ambrogio da Massa, a pilgrimage brings about a thaumaturgic sleep, with the manifest apparition of the saint in dream, only after the ritual actor is back home. While this is not the place to present a survey of the variations in the relationship between sleep-dream and ritual, we may conclude that in hagiographic writing, the dream vision presents itself as an indispensable correlate of the ritual performance. It expresses a cultural schematism, which indicates that the nocturnal half of man has not severed all relations with his diurnal half (Bastide, 1976 [1972]).

It is of interest to note that the preferred way for the thaumaturge saint to manifest himself is the dream vision, which also plays a part in resolving a situation of bondage or the corporeal effects of an improper detention. This trespassing into the realm of justice exists for Pietro Parenzo, as it does for Ambrogio da Massa and Vanna da Orvieto. The agent involved in the performance of the sacred therapy is the same as that with which the saint removes the effects of imprisonment. The underlying reasons for the construction of the thaumaturge saint in hagiographic texts are the same as those, which turn him into a charismatic operator in the political sphere of administrator of justice. The two realms, health and justice, are inescapably intertwined. Deductively formulated arguments of this sort generate lines of interpretation, which provide occasions for empirical verification of the bonds. In the making of the saint, the hagiographic text maintains these bonds with the society it expresses. It hardly needs mentioning here that Pietro Parenzo was the Rector of Orvieto and that in the middle decades of the 13th century the Franciscans and Dominicans took turns at presiding over the Inquisition Tribunal of Orvieto.

The ritual is preferably performed around the sepulchre of the saint: permanently inhabited by an ensemble of personages, who comprise the active public during the thaumaturgic performance, it is the animated stage of the ritual.

First of all there are the “custodians of the body”, military and presbyters for Pietro Parenzo, Franciscans and Dominicans for Ambrogio da Massa and Vanna da Orvieto. It is they who are entrusted with the manipulations required to maintain the corpse’s prerogatives of saintliness. It is they who administer the liturgy and the formalization of acts of faith.

Languentes is most often used to indicate the persons as a group who regularly gather around the remains of the saint. The *egroti* can remain prostrate near the sepulchre for periods as long as a month. This and the details of their transportation on litters and their lying on sandals or linen shrouds let us presuppose that there is an organization for assistance as well as continuous habitation of the site. The participating crowd drawn into the ritual performance is never anonymous, and is there in the form of civic delegations or social representatives to bear witness to a blessing granted or to take part in a ritual pilgrimage. The "animated scenario" around the sepulchre makes the sacred dimension of the space tangible as personages of various social standing approach, presenting themselves as their social rank prescribes: prisoners penitential dragging the instrument of their detention or aristocrats arriving on horseback, to cite only the extremes. Various types of behaviour indicating the individual and collective predisposition to the miracle circulate through the crowd. Everything is interpreted, theologically, as a sign of the miracle. The forms and practices of the ritual and the participation of the public bear witness to the way in which the sacrality of the site and the oneiric forms of support merge. Together they are the coefficients, environmental and situational, of the ritual performance: definitions of its forms of the efficacy of its effects. The pilgrimage to the sepulchre, the exposure over the sepulchre, a prayer vigil by night and a healing in the morning hours all appear in the three texts of the hagiographic corpus of Orvieto. This is the hagiographic rewriting of the classic thaumaturgic institution of the *incubatio*.

The "ritual performance" takes shape in this context. It is centred on the death throes of the saint, a social instrument of health. The hand of the dying saint is guided, in a sort of self-imposition, to touch and indicate the diseased limb. The theme of the increased power of the saint on the day he departs from the world appears. The touch of the saint, *eo die quo migravit*, heals. On the one hand, this can be traced back to an intrinsic characteristic of Christian saintliness, which stresses the prodigious nature of the moment of earthly death. It is a hagiographic *topos* that obviously also invests the local Orvieto saints. On the other hand, the effective circumscribing of the touch to the period of the death throes, with what this means in terms of collocation in situations and places controlled by the entourage of the saint, may also be in antagonistic relationship with the thaumaturgic practices of the Cathar Perfects whose presence in Orvieto is documented in the sentences of the *Liber Inquisitionis*. Their practices in their extra-urban havens used touch and the lying on of hands.

Vows, devotional offerings and pilgrimages, as dictated by the hagiographic cliché, are the conventional forms of ritual. Nevertheless, the Orvieto corpus also reveals the importance assumed by the body of practices based on attempts at contact with the sepulchre. The prostrations, genuflections and lying on the tomb make generic reference to contact with the sepulchre. They are all strongly formalized forms of ritual behaviour pertaining to gesture modes of devotion singled out and adopted by Christianity. In this sense, our texts document the spasmodic nature of attempts at contact with the sepulchre to the point of taking on tones of a paroxysmal attempt to adhere to the tombstone with the body, thus affirming the positiveness of contact between the corporeal site of the disease and the natural element that serves as intermediary for the thaumaturgic virtues of the saint. In the case of children, there is explicit reference to exposures on the tombstone, but within the limits of the "sacred enclosure" even the earth and the sweepings, which are used for making amulets, have apothropaic and thaumaturgic properties.

Notes

(1) This paper summarizes the research carried out in the course of my Dottorato di ricerca in the Methodology of ethno-anthropological research (X cycle, Universities of Siena, Perugia and Cagliari) which was concluded in 1999 with the discussion of the dissertation La santità taumaturgica come dispositivo culturale. Antropologia medica del corpus agiografico di una comunità medievale (Orvieto secc. XII-XIV).

The following have already been published: Petrangeli Enrico, il Podestà e taumaturgo. Focalizzazioni verso una comprensione antropologico-medica della leggenda di Pietro Parenzo, *Annali della Facoltà di Lettere e Filosofia*, 2, Studi Storico-Antropologici, volume XXXI-XXXII, nuova serie volume xvii-xviii, 1993/94-1994/1995, pp. 89-109 and Idem, «Podestà o mendicante o sarta, comunque taumaturgo. Cambiamenti tipologici e persistenza del ruolo terapeutico nella "fabbrica del santo" attraverso la letteratura agiografica orvietana dei secoli XII-XIV,» *AM. Rivista della Società italiana di antropologia medica*, n. 3-4, ottobre 1997, pp. 219-245. It's pubblishing Petrangeli Enrico, *I poteri del santo taumaturgo. Antropologia medica del corpus agiografico di una comunità medievale (Orvieto, secc. XII-XIV)*, prefazione di Franco Cardini, Argo, Lecce, 2003, 200 pp.

This article proposes a framework for the last paper mentioned above and also its basic contents, necessarily in an apodictic form. While preparing it, I felt as if I was working at a patchwork, which I was tempted to justify epistemologically. But then I decided that even in a schematic form it was opportune to let the various lines of research and thematic nodes which I had discovered be known. I obviously leave it to the reader, whom I thank for the attention he dedicates to this paper, to have the final word regarding the value of this work.

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 167-189

Boundaries and continuities: a genealogical approach to some illness representations in Finland

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Introduction

The aim of this article is to introduce a historical approach into our thinking about "medical anthropology at home". Our research field is generally conceptualised with themes and questions of a contemporary nature. In this article, we analyse illness representations – beliefs about heart diseases and depression – with an attempt to relate current everyday life theories to historical ethnomedical archival data in Finland. We will ask whether some of the current modes of representing illnesses reflect past ones, and we will try to conceptualise the relationship in terms of the history of mentalities. This is an idea initiated by the French *Annales* School which focuses on the collective thought structures (e.g. Febvre 1938, Le Goff 1974), that is, a history of attitudes towards everyday life (Hutton 1999). We are searching for "structures of long duration" – as Braudel (1972) puts it – in two different domains: in peoples' ways of thinking about causes of illnesses, and in their ways of shaping moral conceptions embedded in illness representations.

From a perspective of the studies of cultures, everyday life, or "lay (1) theories" – as sociologists put it (cf. Blaxter 1997) – can be considered as windows to cultures. Social and cultural expectations and suppositions about the world, and the varying relationships of human beings with their society, are central elements in these interpretations. Viewed from a perspective of knowledge production, the theories are multi-layered constructions and crystallizations of cultural common sense. In addition to everyday life experiences and historical substance, they absorb elements from current professional theories, mainly biomedical ones. There is a mixture of both – but professional theories too can be considered along the same lines. According to Furnham (1988, 2), a social psychologist, there are a number of criteria among which lay, professional, or scientific, theories may differ.

So, they can be mainly regarded as a continuum of belief systems with which people strive to make sense of how things work both in everyday life and in the sciences. The distinctions between lay and scientific theories are by no means clear and many present scientific theories have even developed from lay belief systems and still contain implicit elements of everyday life. Our first question focuses precisely on the historical layers of a mixture of everyday life/professional illness theories.

Anthropologically, a theoretical ground of everyday life theories of illnesses can be conceptualised by Clifford Geertz´s idea of common sense as a cultural system (1983). In contrast to other cultural systems, common sense merely dwells on practical realities of everyday life and, in order to prove its case, does not need rigorous methods. Common sense rests its case «on the assertion that it is not a case at all, just life in a nutshell. The world is its authority» (ibid. 75). Geertz goes on to argue: «Common-sense wisdom is shamelessly and unapologetically ad hoc. It comes in epigrams, proverbs, *obiter dicta*, jokes, anecdotes, *contents morals* – a clatter of gnomic utterances – not in formal doctrines, axiomised theories, or architechnonic dogmas» (ibid. 90). The content of common sense varies through different cultures, but what is general regarding all cultural systems of common sense are qualities like "naturalness," "practicalness," "thinness," "immethodicalness," and "accessibleness" (ibid. 85). All this is usually at stake with "lay" theories of illnesses.

Common sense is not, however, a transparent collective mind which is entirely free from presuppositions. New elements from various professional, semi-professional, and religious theories are continuously absorbed into its *contenta*. Common sense is changing; it is something that is continuously shaped by history and culture. Moral conceptions are one of these shifting dimensions. The ailments are rarely considered morally neutral but are, rather, intertwined with values. How do the values come into being, and how do they change? What is at stake with "the long duration" of moral conceptions? It is precisely here where we want to address our second questioning, that of morality.

"The diseases" of Finland: a scientific approach

Finland is known for its high incidence of cardiovascular diseases, depression, and suicide. Even though we have lost the leading position in Europe, ischaemic heart disease, IHD, is still our most important cause of death – one third of middle-aged male mortality is due to IHD (Institute of Public Health 1998, Valkonen et al. 1993). What is specific to Finland is the sharp geographical difference in both morbidity and mortality. This is commonly called "the eastern excess," and means about a 50% higher mortality rate in IHD among middle-aged men and 30-40% among middle-aged women for the eastern parts of Finland (2).

Since diagnosis-based mortality statistics became available, "the eastern excess" has been well-documented (Kannisto 1947, Pyörälä & Valkonen 1981, see Koskinen 1994). In fact, this eastern excess in general mortality is a phenomenon that has been recognized from the beginning of the 1850s (Kannisto 1990). He concluded, moreover, that the high rate of mortality in the eastern parts of Finland has long historical roots.

However, this "eastern excess" is associated with other ailments too. Depression rate is high in the area. Suicide mortality is at its maximum in the same area as IHD (Kansanterveyslaitos ibid. Lönnqvist *et al.* 1994). The phenomenon of mortality due to violent causes in general is gendered as well, being a problem mainly of middle-aged men (Valkonen 1985). Koskinen (1994) indicates that suicide incidence among middle-aged men in the eastern parts of Finland has a high correlation with IHD. Looking at the "disease maps" of Finland, one easily recognizes the coextensive regional variation of IHD, depression, and suicide.

Hundreds of preventive and health promotion projects are launched for the prevention of IHD (3) in the Western world – and many of them have succeeded very well in decreasing the morbidity and mortality rates (4). There are also prevention programs for depression and suicide (5). Tens of thousands of epidemiological studies of risk factors have mapped the aetiological backgrounds for IHD, such as smoking, dietary fat, high blood pressure (in combination with high serum fat and cholesterol), and stress levels – something typical and peculiar to our Western style of living. In addition, several studies have been also been carried out about factors of (male) violent behaviour in Finland, including such as traditional excessive drinking at one sitting. What is striking about epidemiological studies is that the historical, social, and cultural contexts of mortality and morbidity are ignored. Yet eastern Finland differs from the western and southern parts of the country in countless ways: history, and social, political and economic circumstances. For anthropological purposes, "eastern excess" should be renamed as "the eastern question." It is perhaps no exaggeration to characterize our "eastern question" by parallels between the cultural geography of Italy, and the "the southern question" of the Italians.

In well-controlled epidemiological studies the Finnish phenomenon of geographical difference is determined, according to Koskinen (1994), mainly by (the genes – he thinks – but also) the region of birth and less by the region of residence. He comes, in his own epidemiological way, close to the cultural and political dimensions of the "eastern question." He notes, furthermore:

> «The main cause for the mortality contrast may be an unknown behavioural or environmental factor which already in childhood or youth exerts its more or less irreversible effect on the adult risk of ischaemic heart disease. Thirdly, we can speculate that the eastern excess is due to some behavioural pattern, relevant in the aetiology of IHD, which is adopted rather permanently already during childhood or youth in the eastern cultural milieu.» (Ibid. 168).

Therefore, what is this *unknown behavioural or environmental factor* or *some behavioural pattern ... which is adopted rather permanently already during childhood ... in the eastern cultural milieu?* Anthropologists start asking questions where epidemiologists stop. As far as the first author of this article is concerned (6), it is precisely where Koskinen concludes that ethnography should start to dig deeper.

Notes on the everyday life theories of "The diseases"

In this paper, we have first analysed some data (7) of current Finnish everyday life theories about heart diseases, *sydäntauti*, and depression, *masennus*. Because the article is based on a project, which is in progress, the analyses are not yet complete. There are three points, which have given us pause to consider.

Firstly, when people talk – and when they are informed through health education programs – about heart diseases, the main reasons mentioned are dietary factors such as animal fat and salt, overweight, lifestyle and hereditary issues. This is not unexpected because these themes, and especially the avoidance of animal fat has been the main content of the extensive heart disease prevention and health education programs launched at the beginning of the 1970's in Finland. The most famous is internationally known as The North Karelian Project (8) (e.g. Puska *et al.* 1995). The programs have been effective, and since the beginning of the 1970's, the majority of the population has changed their eating habits and adopted a less "traditional," less animal fat-saturated diet. Thus, "lay" theories are *par excellence* beliefs, which are subtly intertwined with professional ones. The focus on eating and faulty diet is, however, so prominent, that we would like to concentrate on it. Would it be possible to search for the genealogy of these beliefs? If so, would the ethnomedical material provide us with answers?

Secondly, depression in current everyday life theories seems to result from losses stemming from an unhappy childhood or from strain in working life. “Burn out” problems are currently well known but are in any case newcomers to this theoretical area (Tontti 2000). What Finnish people talk about most when they illustrate their depression theories is a sense of loss and abandonment. This echoes, of course, a well-known register of Freudian psychoanalytic thinking about psychological problems. In addition, there are discourses of destiny, as well as the heritability of the illnesses (Kangas 1999).

Thirdly, illness representations are also intertwined with interesting and notable moral questions. Put straightforwardly, People State that they are more or less responsible for heart diseases as autonomous agents, who may decide about their ways of eating and living. However, as far as depression is concerned, they feel that they are victims of their childhood or, more broadly, that they are victims of things beyond their control. Putting the etiological discourses and the moral continuum into the context of Finnish social life gives an interesting glimpse on some central cultural values in society, such as autonomy and independence (concerning the Finns’ central cultural values, see Roberts 1989, Abrahams 1992). For decades, health education programs have emphasized issues of autonomy and have included the idea of victim blaming.

Moreover, cultural assumptions of good and honoured ways of dying are an interesting dimension in the domain of responsibility and autonomy. Death by heart disease is/has been regarded as a honourable way of passing away, especially among Finnish men (Valkonen 1994). Suicide has a similar reputation – honourable men draw honourable conclusions to lives that have gone wrong (9). Are not these crystallizations of the value of autonomy? According to a well-known Finnish proverb, cardiac death is passing away with one’s boots on. This is often regarded as a result and also a sign of a respectable life with much hard work and even an overload of such work – this echoes values of a Lutheran work culture at its best.

To recapitulate, what we wanted to do was to look beyond the contemporary ways of representing illnesses and ask whether these, also in moral terms, would reflect something which was present in old folk belief systems?

Field work in the Finnish Folklore Archives

Our ethnomedical data is archival material from the Finnish Literature Society Folklore Archives.

Even though we analyse old texts, this study is ethnographic in the sense Sherry Ortner (1995) conceives it. The fieldwork is not from a strict geographic area and in that, sense does not constitute a concrete "field." The historical archive data we will draw upon does not make possible the kinds of contextualisations that are needed in "thick description", but our methodological position echoes an "ethnographic stance" in the Ortnerian meaning: textual research can be ethnographic too. Moreover, as in ethnographic research more generally, the texts here are also products of the informants' agency in various social interactions.

The main source of the data is archival folk material from the Folklore Archives' Ethnomedical index, which covers a historical period of more than a century. The oldest folklore material was collected in the early 19th century. Geographically, most material is from the eastern parts of the country, from Savo and North Karelia, which are also more extensively represented in the archives. The newest information is from the early decades of the 20th century. The classification of material is based on various names and indigenous titles of diseases. This article is a brief excursion into the material, and we have concentrated mostly on causal explanations of diseases and have almost totally left out the *loitsu* material, incantations, which were used in healing. The incantations contain about 52,000 poems, 30,000 of which are published in *Suomen Kansan Vanhat Runot, Ancient Poems of the Finnish People*, a 33-volume series (10).

We focused on the ethnomedical index's data on heart diseases and melancholy – at that period of time there were, of course, no 'cardiovascular diseases', *sepelvaltimotauti,* or 'depression', *masennus,* which are their modern indigenous names. We found only a couple of references to heart disease as such. The local categories were 'stab diseases', heart symptoms caused by stabs, *pistos* and by someone being stabbed to death. We also found heart symptoms within the category of attacks, *kohtaus.* We carefully studied categories of 'mental disturbances', *mielenhäiriö,* and 'madness', *hulluus,* in order to learn what mind and mental diseases meant. We found four local indigenous categories, which can stand for the mental content of what is meant by 'depression': *jalan peälys, muan veto, alakulo and synkkämielisyys*. The first two have meanings that connotate something which is heavy and draws one down to earth; the second pair of terms have more to do with what is meant by 'melancholy.' One indigenous category, *mara*, was associated with nightmares.

We have also made use of "the belief" and "folk belief index" of the archives, which were rich in data on magic and 'disease raising,' *taudinnostatus*. We shall focus on this below. The index was not an easy place for fieldwork, because the material varied a lot. There were some short descriptions, while others were longer and more detailed. The collectors were different people with different backgrounds and interests. Some of them asked explicitly about the causes of disease and some were more interested in the healing process and in healers, *parantaja*.

Disease concepts and causal categories

The folk categorization of illness differs radically from our modern biomedical ways. As readers of Levy-Bruhl (1923), we know how traditional modes of thought and folk categorization are devoid of dichotomies and allow a 'both – and' ground for classification. Due to this lack of dichotomous thinking, the borders of categories do not exclude each other but allow a simultaneous presence (Kurki 1995). In the archives, it was not an easy task to follow and actually understand this. In addition, what made the work even more difficult was that people designated both causes and diseases by the same name and a disease could have several names, some of which were synonymous with the causes.

The cosmological worldview of the agrarian population in 19th-century Finland can be divided up into four domains. The sharply dualistic view of the world consisted of '*this world*' or '*this air*', *tämänpuoleinen*, and '*other side*' (*tuonpuoleinen, tuonilmainen*) which had a mirror image relation to each other. Living humans occupied the former, whereas the supranormal, the sacred, the dead, the spirits, the holy figures of Christianity and God occupied the latter. The boundary between 'this world' and 'the other side' was not sharp or exclusive but several otherworldly spirits, especially place spirits, lived in the domain of this world. They were located as spirits, *haltia* (11), for example in water, forests, or anthills, and in dwellings.

During the 19th century, the healer, literally 'knower,' *tietäjä*, was central in the cosmology. The *tietäjä* was able to manipulate supranormal forces and beings; that is, he or she had competence, which was based and founded on secret knowledge of supranormal forces and influences, as well as ritual control over them (Siikala 1992). Historically, the layers of mythical thought make the figure of *tietäjä* distinctive from older, earlier representations of healers, or shamans. In the Finnish belief system, the *tietäjä* was able to use spoken incantations, which were seen to possess a power of their own.

“A power of their own”, present in spoken incantations, but also in nature – actually in all beings and categories of beings was called *väki* in the old Finnish cosmology (Manninen 1922, Haavio 1942). *Väki* is a dynamistic concept, which is close to the Melanesian concept of *mana* or the Iroquois concept of *orenda*. An American-born Finnish anthropologist, Laura Stark-Arola (1998, 120), defines the difference interestingly:

> «The folk or emic concept of *väki* in Finnish magic is much more restricted and ‘concrete’ than either *mana* or *orenda:* it can be likened to the idea of mobile energy force whose transference and effect on other entities, as well as the corresponding reactions it receives from other *väkis*, are central. Close proximity and a clear, unobstructed path to its target, if not actual physical contact, were thought to be needed for its transference. (...) Unlike the concept of *mana,* there were no specialized *väkis* to make people wealthy and to kill people, and while *väki* may have been described emically as ‘powerful’, it was never seen to be ‘heavy’ or ‘hot’ as with *mana* (see Mauss 1974/1904:109). *Väki* was the essence of an object or animate being, but not the power evoked by a magic ritual or incantation. In other words, *väki* was not the same as magical and mystical force in general, as Mauss argued for *mana* and *orenda*.»

Väki was a kind of impersonal force, which belonged to all beings and phenomena (Hautala 1960, 13); even incantations contained *väki* – which was why they had powerful curative effect. *Väki* was hidden when it was not a target of interest, but in emotional circumstances it become “activated” (Hautala’s own term). There were a number of different entities, which were believed to possess *väki*. Because people were understood to be ‘open’ (vulnerable and unguarded) towards certain *väkis*, people thought that *väki* could in some way be transmitted, *hinkautua*, to humans.

The types of *väki,* which are important for understanding ethnomedical material, are briefly listed below (Stark-Arola 1998, 121).

Kalman väki: the dynamistic force of death, *kalma,* believed to reside in corpses, cemeteries, and other things associated with gravesites, burial etc. *Kalman väki* was thought to be extremely powerful and it was used in various practices, notably in ‘disease raising’ (see below in more detail).

Metsän väki: The dynamistic force located in the forest, *metsä,* or in trees, notably in bears, or forest animals in general.

Veden väki: The dynamistic force located in natural bodies of water, *vesi,* especially in lakes and ponds but also streaming rivers.

Maan väki: The dynamistic force located in the earth or ground, *maa.*

Löylyn väki: The dynamistic force located within the steam of the sauna bath.

Tulen väki: The dynamistic force located in fire, whether an open fire, or in a baking oven, or sauna stove. This *väki* was capable of transmitting, if treated badly, but in many cases it was also healing.

Female *väki* (12): The dynamistic force located in female genitalia and reproductive organs. Female *väki* was powerful, even strong enough to ward off the evil eye, and there is no evidence that women themselves could be exposed to the evil eye while protecting others from it. On the other hand, the female *väki* was not always considered a benevolent force. It was also seen to have a capacity to prevent human wounds from healing or ruin objects, to harm horses or endanger children through *harakoiminen* (jumping, stepping, or standing with spread legs over or on an object, thereby putting it into direct proximity of the female genitalia). That the powers encountered in the vagina's wrath, *vitun vihat*, and released through *harakoiminen* were seen to be the same is supported by at least one folk belief text:

> «The 'wrath of women' transmits, when women are bathing with you at the same time or if they otherwise simply *harakoi*» (Stark-Arola, ibid. 121-122).

Incantations were also considered to be powerful and to contain *väki*. In the Finnish practice of traditional healing, the meaning of incantations was remarkable. The words in incantations were part of the object that was referred to. The structure of incantations, for example, was important: in order to fulfil the healing power, the healer must know the exact order of the words in the incantations; every detail in this order was meaningful (Siikala 1992).

The concept of luck, *onni*, is an important dimension of the old Finnish cosmology. According to a Finnish ethnologist, Toivo Vuorela (1960), the image of fortune or luck, *onni,* as a limited good was crucial in the Finnish folk belief system. The Finnish-Karelian concept of *onni* refers to a known, bounded amount, of which the villagers had a share. If someone's *onni* decreased, people thought it was because someone else stole a bigger share. Usually it was thought that such an imbalance was induced through illegitimate means, such as magic or sorcery. Moreover, if someone had a bigger share, it was justified to do harm to and inflict 'disease rising' on him/her. The issue with a bounded good was even more problematic in Finnish traditional culture because 'other-worldly,' *tuonpuoleinen*, beings were prone to share the 'this-worldly', *tämänilmainen*, well. «They used to capture the villagers' animals, or children; cattle could be stolen by the forest spirit, trapped in the forest-cover *metsänpeitto*, or even taken by the water spirit,» Laura Stark-Arola writes (ibid. 119). Envy and the 'evil eye' were closely related with these practices, and constitute well-known motivations in Finnish culture.

The folk belief system and the consequent illness representations are understandable in the context of nineteenth-century Finnish agricultural society. It was an extremely closed social and economic system, without many connections to the outside world. The agrarian wealth and crop were limited and the cosmological concept of *onni* actually echoed the this-worldly reality. If someone received more, then it was absent from the others' share. Diseases were understood as threats and crises, which threatened the individual *and* shattered his/her society. Of course, it was not only 'other-worldly' powers that victimized the humans but also the villagers themselves. The social practice called 'disease raising,' *taudinnostatus,* was a name for all the practices by which people made each other sick. In order to do so, they used *väki,* which was abundantly present in nature and within them.

Finnish ways of getting ill – Frightened, 'stabbed', or fed sick?

When someone became ill, the healer, *tietäjä,* was responsible for the etiological categorization and the consequent cure. The Finnish ethnomedical categorization included two general classes, the serious and often deadly 'God's diseases,' *jumalantaudit,* and illnesses which were brought about by envious or malevolent people, *panentataudit* (Lönnrot 1832). However, in addition to these two, the healers could have a plenitude of various causal theories. It was always a challenge for the *tietäjä* to find out which illness was at stake.

In the archival material, one example tells us the following:

> «By dreams one (the knower, *tietäjä*) must find out how the diseased has become insane; has he been fed or are the origins of the disease somehow different, without other humans being responsible for it, as it is with fright.» (Koljonen (13) 1980).

According to Anni Lehtonen, a woman who was the most famous rune singer in the country:

> «There are two kinds of illnesses: real God's diseases and then those that originate from bad people or that are transmitted, *hinkautuneita,* in other ways.» (Anni Lehtonen 1924).

Madness was classified in three categories:

> «There are three kinds of madness: one that comes from the wind, one from 'raising' (illness) and the third from fright. The one from raising is from witchcraft practices people do on each other.» (Samuli Paulaharju 1924).

The classification above is the basis of this presentation. We have grouped the diseases by the causative, etiological factors and by responsibility categories. We will start with 'fright diseases and loss of soul,' *säikähdys.* Then we will go on to 'stab diseases,' *pistostaudit* and, finally, we will have a look at 'disease raising,' *taudinnostatus,* and at the practices with which people used malevolent disease raising on other people, that is, by feeding them with *väki*-containing material.

Fright, säikähdys, *and loss of soul*

The first major group of etiological factors includes fright, *säikähdys,* or to become frightened, which illustrates victimization and innocence. One could not be totally responsible for being frightened but the victimhood was not complete. The archival material listed predisposing factors, which made people more prone to fright, such as personal sensitivity and vulnerability, *rieskahenkisyys*. People classified pregnancy and menstruation as life conditions with less protection, and under such circumstances women could easily be frightened. In particular, places such as cemeteries, or activities such as handling corpses, could cause fright. When planning a remedy, the healer, *tietäjä,* wanted to know exactly where the patient had been frightened. The place was essential for the correct naming. The result of fright was loss of soul – or becoming possessed with a *väki*; the results were usually loss of energy; going mad, becoming bloodless, pale, or powerless (Siikala 1992).

As a result of fright, one could become 'infected' (14), *hinkautua*, by *kalman väki* which had the power of transmitting a disease. In the forest, one could be *hinkautunut* by the forest *väki,* in the wind by the wind *väki, tuulenväki*. The anthills could hide *metsänväki;* one had to be careful about still waters but also careful about currents of the stream, on account of *vesihiisi,* the water spirit that lived there. Wind *väki* could fly on the wind. The archival material was quite rich with preventative rules and advice for women – and for people more generally. It was supposed that people learned and knew them and also taught them to their children, and in this way they were held responsible for the prevention of "possession" by the various *väki.*

> «If one moved in the forest, one could easily become frightened. The forest spirit, *metsännenä,* comes from the forest. Afterwards it is impossible to find peace, especially during the nights.» (Matti Hako, Viena Karelia).

According to old Finnish cosmology, human beings were protected by a *haltia,* a protective place spirit, not unlike the later Christian figure, a guardian angel. When individuals became frightened, they lost their *haltia*. Persons could also lose the *haltia* in their sleep. Sometimes a *haltia* was absent for long periods of time, as it could stay in the 'other-world,' *manala,* or take the shape of an animal. When a *haltia* was lost, people felt weak, "white-blooded," *valkeaverinen*, powerless – blood was also believed to contain essences of life in the Finnish folk belief system. An early mention of 'depression,' however, was found in western Finland (Harva 1948), the «depressed person had lost his *haltia.*» Moreover, a definition of people who easily fell ill was such that they had "weak *haltias.*" If the *haltias* were weak, *väki* from various places had easier access to the body and could induce different types of illnesses. *Haltia* could also be lost by inter-subjective human means; that is, according to the tales in the archive material an envious and malevolent gaze could induce this loss. The *haltia* could also be stolen. Whatever the means by which individuals lost their haltia, the results were inevitably detrimental. This loss also caused several forms of madness, but also caused 'attacks,' *kohtauksia*, which included sudden attacks of pain and heart problems.

'Stab' diseases

The second major group of etiological factors in the archive material are 'stab' diseases, an important group of heart diseases. They include *pistokset, ammukset, lävykset*, *raippaukse*t and *pistännökset*, caused by some sort of disease projectile (Honko 1959). The shot, *ammus*, could come with the wind but the victim did not know how or where. The shot could be a pile, or needle, or a hair of an animal, a stone, a piece of glass, or a small animal (Honko 1959). «They just came, as if, for example, on the wind,» as the informant stated above. The innocence of the victim was almost complete; people who were victimized could not have an impact on the shooters, who were mostly beings from the 'other world' (Honko 1959), mythical beings or 'bad spirits' (Pentikäinen 1971).

> «Stab is a disease that pierces your shoulders and breast and the chest and if it pierces the left side of the chest then you will not recover. It is a God's disease.» (Ranni G. 1890).

However, in the rural society of 150 years ago, hard work was considered a cause of heart disease. In one passage the informant claimed:

> «Stab is caused by hard work and heavy lifting. It was such that it pierced the breast and chest, so that you almost died and choked to death.» (Maija Kivekäs 1855).

Generally, it seems that people's chances of protecting themselves from 'stabs' were scanty – or non-existent. Matti Sarmela´s (1994) observation of stabs as a metaphor for the contingency of life is quite justified, insofar as individuals simply became victims and were not able to protect themselves in any way.

Feeding the neighbor sick: 'disease raising' with food

The third major group of etiological factors can be presented by a mundane, 'this-worldly' *tämänilmainen*, group of diseases which were caused and organized by several interactive practices, by 'disease raising,' *taudinnostatus*. Here the active agents were not specialists, but ordinary villagers or neighbours in the traditional rural communities. There were several social reasons for practising disease raising on other people and we will come to this point later. People used to 'raise diseases' by feeding: treating a cup of coffee, spirits or food, which contained *väki* and had the power to cause harm:

> «If someone wants to make another individual crazy, he shall do as follows: If you want to make him melancholic, you may take three grains of sand from a crossroad and put them into a glass with spirits. Then treat the man you intend to make crazy; the stuff in coffee has the same effect.» (Eino Mäkinen 1938).

The composition of the material that was fed to people varied. It could contain, for example, mouse eyes – a material that was notorious for its immediate and powerful effect – but often something that was dug, or scooped out from the grave yard, and contained *kalman väki*. This powerful *väki* was present in soil, pieces of coffins, worms, but sometimes pieces of corpses were needed:

> «The head of the church *väki* was a church spirit, *haltia*. If you were a believer, it could give you good things. You could get bad *väki* if you took soil from the graveyard. If you put it into a drink you could make the drinker insane or diseased with the disease that you are thinking as a giver.» (Konsta Lindholm 1938).

The source of *kalman väki* was also corpses, which were cleaned in the death rituals. People reported that they knew older women who were entitled to do the ritual job, but abused their honoured position by taking and cutting pieces off the corpse (for example, the tongue). If pieces of the corpse were ground and put into the victim's dinner, she or he became insane almost immediately:

> «She had made meat balls out of the tongue of the deceased and then fed it to the brother of Antti Kaustinen and he became mad. The woman had cleaned the corpse in Pöyhönen (a house name) and had secretly cut the

> tongue for preparing the meatballs. She, the wife of Mooses, is a cleaner (a ritual person, a specialist) but everyone must be careful to keep an eye on her so that she won't be able to do these cuts.» (Iisakki Hakala 1932).

People believed that the feeding of material that contained *väki* was more powerful than other ways of practising 'disease raising.' The touch from *inside* was considered the immediate touch. It is difficult to know exactly how and where feeding of the powerful material actually took place. According to archive data, the practices were very secret and were kept most hidden. Several authors emphasize the meaning of secrecy; indeed, the power was in the ritual's secrecy (Vuorela 1960, see also Luhrman 1989).

Kinship relations confer social positions within the framework of the feeding rituals. The relationship between mothers-in-law, *anoppi*, and daughters-in-law, *miniä*, were often bad; abundant folklore tales report cruel mothers-in-law (Nenola 1986, Heikkinen 1990). We have collected passages, for example, with mothers-in-law practising 'disease raising' on their new relatives:

> «One woman had become mad. The husband had asked whether there was any hope or was it a God's disease. The husband sent somebody after the healer (*tietäjä*). It was the healer´s task to find out the cause of the disease. First he didn't answer, but then people forced him to. Then the healer told him that the mother-in-law, *anoppi*, was the cause of this madness. When the mother-in-law heard the healer's words, she started to shout, crawl and creep, and so everyone noticed that the mother-in-law was guilty for the disease of her daughter-in-law.» (Matti Korhonen 1936, 85 years).

Some of the methods that the mothers-in-law used were illustrated as follows:

> «When the daughter-in-law, *miniä,* is brought to the farm, she goes mad if serpents' heads and corpses bones are put into the wedding bed.» (S. Siren 1891).

With the exception of the practices against daughters-in-law, people did not practise 'disease raising' on members of the same family – however, there are some examples of disputes over inheritance. The reason for treating the young women so badly and harshly was mainly due to their position at the bottom of the scale as newcomers in the family. Symbolically, they also represented the 'outside' and only gradually came to the 'inside' position, only after first giving birth to several children.

Envy, *kateus,* was mentioned as an additional reason for 'disease raising' (Vuorela 1960). Finnish rural villages were a closed economic and social system where the agricultural products were bounded – and often limited. Everyone should receive a reasonable part of the crop. Nevertheless, because it was limited, a general idea was that if someone received more, the rest would lose his or her rightful share. This is a fundamental principle of the old Finnish cosmology, and grounded, furthermore, in the idea of *onni*, 'limited good.' As mentioned earlier, 'other-worldly beings' were also prone and eager to share in this 'good' with the villagers. The more the population in the village – and the number of potential dividers – grew, the greater was the incentive within rural social life to make the other sick.

Structures of long duration?

Viewed from the perspective of " structures of long duration," traditional Finnish causal beliefs and everyday life's illness representations are tightly bound to social interactions. At their core, both the traditional and contemporary ways of explaining affliction contain a similar structure: people get sick when something is *added* to their bodies, as in stab diseases, in 'disease raising,' and in modern everyday life and epidemiological theories of heart diseases. Furthermore, people get sick when something is *taken away* as in fright and loss of soul, or in depression theories. In ethnomedical material, people fell ill when they were (actively and intersubjectively) fed with something "powerful and dangerous," but in current heart disease discourses, traditional Finnish food containing animal fat – with its connotations of the Finnish past and the peasant society – is considered the main cause for cardiovascular diseases. One's mouth is still the main avenue for heart disease. Anthropologically, the meaning of food in modern preventative heart disease projects is interesting. Of course, the fact is that excess animal fat causes increased risk of cardiovascular diseases at the population level. However, only 50% of risks consist of factors mediated by eating (*Circulation* 2000) and the projects concentrate only on the behavioural issues in people's lifestyles; especially on eating. In Finland, the food issue cannot be analysed without taking into account the rapid and painful structural social change of the country (15). Traditional Finnish food prepared in and for a rural society – for working people in the farms and for lumberjacks in the forests – is embedded with implicit meanings and symbols, which shape the boundaries of modern Finnish life. The traditional, Eastern and Karelian, is regarded as dangerous for people's health.

In Finnish folklore material, people did 'disease raising' on each other and, in social interactions with their neighbours and other villagers, made each other sick. In current psychiatry and cardiology, and in everyday theories, which are nourished by these two, social interactions are still important. Juha Soivio has interview passages where *wives* of cardiac patients are described as «a heavy users of animal fat» (Soivio 2000). Currently, social agency is shared among other detrimental agents: in addition to wives, anatomical, physiological and genetic agents are also at play. Cholesterol in the Finnish heart prevention programs is a kind of "being" that gradually increases the probability of an early death due to cardiovascular disease. However, since wives have the main responsibility for regulating cholesterol in the daily diet, they are active agents. From the beginning of the North Karelian prevention project, the local women have been active in realizing the dietary change (16). In a way, one could argue that Finnish women have become a New National Task Force as eradicators of the deadly folk disease. Along with the extensive prevention programs, the female task seems to be that of Manager for Modernity.

In psychiatric and "lay" beliefs about depression, childhood events are still considered the main cause of the illness, even though new "stress and strain" theories receive more space in the negotiations of interpretative models. Two interesting traits are to be found. On the one hand, everyday life theories of depression often describe quite literally losses in childhood and faulty motherhood during the early years as causal agents of current depression. In addition, as the consequence of parent's divorce, and unhappy events *within the nuclear family*, without symbolic and representational mediation, which is distinctive of psychodynamic ways of understanding and explaining mental disturbances (17)? Causality of the mental problems is constructed as "concrete" events; indeed, the real mothers within the faulty interactions in one's childhood are there to be found. Put semiotically, in everyday life theories, the sign does *not refer to* its referent but is *one with it* (Foucault 1973). These theories resemble ideological phenomena of reification, which are present in fundamentalist groups of all kinds. On the other hand, in their interpretative practices, people in modern societies have taken an expert position. The "lay" theories of mental problems resemble the "semi-expert systems of illness explanation," a concept that Linde (1987) has applied in her study on lay beliefs. A semi-expert system is for Linde an explanatory system, which is related but not equivalent to either belief systems, shared by entire culture or belief systems exclusive to some group of experts. In order to make sense of their life stories, middle class Americans used to cull both popular and Freudian, Marxist and various religious explanatory theories. However, what took place in the biographical accounts was that people applied Freudian psychology in a "thin" sense. The concepts, which are borrowed, are not embedded in the entire Freudian theory but are isolated. They also lack the dense interconnections of Freud's argumentation. In addition, Linde emphasizes that popular Freudian theories did not contradict other popular theories of the mind, nor reasons for human behaviour. They were applied in a supplementary way.

The harm done by social interactions was extremely concrete in the archival material too. There is, however, one important difference between the materials. 'Disease raising' was not done on members of one's family or relatives who lived in the same farming household (Stark-Arola 1998). On the contrary, the material is rich in "good, benevolent magic" that mothers practised in order to protect their children, for example, against the 'evil eye.' The only exceptions were new daughters-in-law, who represented the symbolic 'outside', Otherwise, because they came from another household and only gradually became integrated into the family. Mothers-in-law were quite active disease raisers at the beginning of their sons' marriages. Some examples of quarrels and contentions concerning inheritance had caused disease raising within the members of the same household, but the examples are rare (18). It is tempting to interpret this by representative theories about split motherhood; in the folklore texts the good mothers were the biological mothers and consequently benefactors, and the bad ones were split away, represented by mothers-in-law and stepmothers. In order to be proved, the claim needs further study – but what is certainly anthropologically at stake is a cultural change in the notion of kinship; especially concerning the definition of its 'inside' and 'outside'.

Diseases and moral conceptions

Disorders give rise to pressing moral questions which people try to answer throughout the course of illnesses – when they break out, when choices between different healing practices are made, and when recovery is expected. Values are embedded in illness discourses. Disorders are inevitably related to emotional and moral worlds, and notions about disease and healing emerge out of an organizing realm of moral concerns (Douglas 1966). These moral discourses are fundamentally and explicitly used to organize diagnoses, narratives of illness, and healing rituals.

The name of the disease	**Cause, casual agent**	**The patient's on responsibility**	**Innocence**
"Disease raising" by Food	A neighbour, villager, a relative from another household, mother-in-law	Evil doings, revenge, wrong ways of showing one's fortune	Social position such as a new daighter-in-law
Stab disease	Some other-worldly spirit		Contingency
Fright, loss of soul Heart disease	*Väki*, other people (seldom)	Consciousness of dangers, of preventative rules, norms	Disposition, weak *haltia, rieskahenkisyys*
Depression	Danferous food, traditional fatty food, smoking, ways of life, hard work hard life	The same	Genetic disposition, 'the Finnish hero'
	Mother, childhood in nuclear family, social interactions in job, massive strain and stress, "burn out"		Psychological disposition, social vulnerability, destiny

In traditional Finnish rural life, illness beliefs include explicit moral issues. Diseases had aetiologies and causes but they also led to questions of *guilt*. According to a prominent theory of the ritual of affliction (Honko 1959), the disease event was experienced as a crisis, which threatened the community. The healing rite was a profoundly social ritual, a ritual of affliction, which intended to find the reason for the threat and enhanced social cohesion, togetherness, and undisturbed interactions in the group (Honko 1959, Siikala 1979). The task of the healer was to find the cause of the illness and, simultaneously, detect the person who was *guilty* for the event. «When the threat was eliminated, and the evil doer was found, the life of the group could go on without disturbances», writes Lauri Honko (ibid. 1959).

The ways people handled causes of diseases touch upon questions of innocence, guilt and responsibility. From the beginning of the 1970s, the strong emphasis on individual responsibility in cardiovascular disease prevention programs has encouraged victim blaming and caused guilt among the sufferers and their relatives. However, some illness representations are met with total innocence, and, interestingly, this seems to be the case with mental illnesses (19). In traditional Finnish archival material, innocence was connected with the stab diseases: the shots just came and people could not defend themselves. Furthermore, it was difficult to protect oneself against disease raising, simply because, for example, it was difficult to be certain of the content of one's food. The only way of protecting oneself was probably to hide one's own fortune, *onni*.

The attitudes towards 'fright' were more ambiguous. On the one hand, people were totally innocent; they just lost their soul or their protector, *haltia,* without being able to control the situation. On the other hand, by learning rules and heeding advice about dangerous places and vulnerable life conditions people went on living their perilous lives. These preventative rules constituted, interestingly, core issues of autonomy that were made to grow alongside the social and economic changes taking place in the rural society.

Concluding remarks

There are several ways of thinking about mentalities (Ginzburg 1976/1980, Le Goff 1974); they may be regarded as consisting of shared ways of experiencing, ways of knowing and feeling, both conscious and unconscious. In short, by the history of mentalities we mean the history of the attitudes of ordinary people towards their everyday life. The central question of this article has been whether the ways of representing and explaining illnesses would be understood as collective, mental, and social structures of long duration in the sense Braudel uses in his treatise on the history of the Mediterranean (1972).

In this paper, we have presented the question of whether or not the intense meaning of food, in the Finnish everyday life theories of heart diseases and professional prevention programs, could resonate with former Finnish ways of bestowing meaning upon eating. On the other hand, whether or not meanings of loss could possibly echo the older ways of understanding melancholic mental problems. However, a powerful cultural register, biomedicine, has emerged within the middle of the study period. Heart disease prevention programs look very similar in Western countries, and so do the lay theories as well (Emslie 2001); smoking, for example, is prohibited and considered a sinful behaviour in most EU countries and the US even though there is a variation in the sinfulness. Cholesterol-containing food is generally considered dangerous. The contents of prevention programs should be carefully read and the illness causation theories in Western countries compared in order to prove our argument. Similarly, within the area of mental diseases, psychiatry has established its impact on people's ways of understanding depression. We argue that an archaeology of psychiatric knowledge is also needed – where does the Freudian "loss of object" come from, as looked at from a perspective of the history of mentalities? Furthermore, talking about mental problems necessitates taking into account a magnitude of religious impacts. In conclusion, there is certainly no straight line from the past towards contemporary ways of believing and thinking of illnesses. Nevertheless, modes of thinking are embedded in historical and cultural contexts in various and interesting ways, and their exploration is, we would argue, an important task for a medical anthropology at home.

Notes

(1) We use the term "lay" in quotation marks. It has a connotation connected with the dichotomy lay/professional which we want to question. In addition, regarding their illnesses in the context of their culture, people are "lay" only in a thin – and often biomedical – meaning.

(2) There has been historical variation in this "eastern excess." In the 1960s and at the beginning of the 1970s, the eastern mortality in IHD among middle-aged men exceeded the southwestern provinces by 60-70% (Koskinen 1994,148).

(3) Population-based intervention programs such as the North Karelian project – which Finland is famous for – Monica, FinnMonica (WHO) have carried out in Finland, in North Karelia, since the early 1970s.

(4) This is controversial, however. According to Valkonen et al (1990), mortality in IHD had already started to decline in early 1970, before the North Carelian project started.

(5) In Finland, prevention of depression was regarded as one of the most important preventative tasks in suicide prevention. This has had a tremendous impact on the use of antidepressive medication.

(6) In 1999, I started a five-year medical anthropological project "Expressions of Suffering – Ethnographies of Cardiovascular Diseases, Depression and Suicide in Finnish Contexts." One aim of the project is to understand the current everyday and professional ways of explaining these three, and to interrelate them with each other. I argue that heart diseases and suicide are bound together with an internal tie of meaning; the support for this argument is based both on Finnish folklore poems, which are rich in this theme, and on a very different point of view concerning some current epidemiological and psychiatric literature. For further information about the project, see www.helsinki.fi/hum/antropologia/medantro.htm

(7) We have made extensive use here of Finnish material published for prevention purposes. Two large, nation-wide projects in Finland, The North Karelia Project (several publications, here e.g. 1995) and The National Suicide Prevention Project (several publications, mostly in Finnish), health education material, such as magazines, heart patients' organizations' publications etc., are our main sources. The main message can be summarized as "In modern society, people are considered responsible for their heart diseases. They are autonomous agents who decide what to eat and how to organize daily work out."

The first author's fieldwork, M-LH, in a North Karelian village and the interviews have started, the project is in progress.

(8) The North Karelian Project 1995. Finnish cardiovascular morbidity and mortality have long been the highest in Europe. The suicide mortality is about 40/100, 000 men in 1998, which is the highest in Europe. Every other year the highest figures are Hungarian.

(9) See Honkasalo n.d., a manuscript.

(10) Between 1816 and 1970 about 4, 000 incantation examples were collected from North Karelia; the most prolific period of collecting was 1880 and 1890.

(11) Literally “protector” and “possessor”. *Haltia* is a place spirit, dwelling in places in the natural environment or a cultural environment. *Haltia* is also a model of the later Christian Angel figure.

(12) Laura Stark-Arola’s interesting Ph.D. thesis, Magic, Body and Social Order, is about Finnish women’s secret magic rituals in traditional Finnish culture and she discusses questions about female *väki* in detail in the book.

(13) The name of the informant in the archival material.

(14) The translation is difficult. *Hinkautua* has a meaning that can be translated as ‘transmitting’ a disease, but in an almost possessive manner. The *väki* that *hinkautuu*, (‘transmits’) goes inside the body of the afflicted. Laura Stark-Arola uses the term ‘infect’, which, however, is not very good either, because it has a connotation connected with contemporary biomedicine.

(15) After the Second World War (in Finland the Winter War 1939-1940 and the Continuation War 1941-1944) Finland was almost entirely agricultural. The structural changes started as late as the 1960s and have now totally altered the social picture of the country. Nowadays only about 6 percent of the workforce consist of people working in agriculture and forests.

(16) Ellen Marakovitz, an American anthropologist, makes some interesting points on this issue. In the 1980s, she did ethnographic fieldwork on Finnish women’s political movements. She calls one of them, a prominent one with a hundred-year-long history and a present membership of about 80,000, as “national caretakers” and emphasizes how women’s activities in the movement are directed to the welfare of the family, and by extension, the nation. «The caretaker idea of what it means to be female supports, and is also supported by, the Finnish social welfare state. This national narrative constitutes the caretakers as the agents of the state,» she concludes (1993, 84).

(17) We have collected preliminary material from various Finnish health magazines, ladies’ magazines and some novels. It is striking how mothers are blamed: they “really have been absent,” “abandoning” - working probably in paid work outside the home, as 90% of Finnish women have done since the Second World War.

(18) Pentikäinen 1971.

(19) Of course, behind the question of innocence with respect to mental illnesses, there are many layers of discourse embedded within Western moral history. In the medieval era, depression was a mortal sin, *acedia*. Only gradually did it grow out of the domain of guilt per se, and become defined as a “disease” on the psychiatric register in the late nineteenth century (Jackson 1986).

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 191-204

Health, charismatic cults and contemporary folk culture

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1. The charismatic Catholic communities

The movement of charismatic renewal arose among the American Catholic communities at the end of the sixties. In the last 30 years it has spread dramatically throughout the world – industrialised and not – mainly among the well educated middle urban classes. Now, in all the continents there are communities that, even though they have different organisational structures, claim to be a more or less organic part of this movement (1). It is not rare to witness large national and transnational meetings attended by international leaders of the movement, who travel in different nations collecting crowds of believers everywhere. Such meetings strengthen the ties among the communities, making it possible for them to communicate, exchange information and discuss doctrine.

The movement arose as an attempt to renew the spirit of the Catholic Church. It was centred on a new dimension in which faith can be experienced directly by the believer through an attenuation of the mediating role, between man and God, of the institutional sacral staff (the priests and Catholic hierarchy), and forging a more personal relationship between him and the divine (mainly Jesus and the Holy Spirit). A sign of this relationship, and of the power that characterises it, are the gifts of the Holy Spirit, that is to say, the charismas as defined from Paul in the *First letter to the Corinthians*.

In the last 20 years the charismatic renewal has also spread in Italy. It should be pointed out that it has spread equally in urban and rural areas, chiefly through small communities or simple prayer groups: that is, groups of individuals that periodically gather in an informal way to beg and invoke the descent of the Holy Spirit. The phenomenon has interested various anthropologists who have produced a number of studies (2). Two elements are usually stressed: a) the ideology that permeates charismatic communities; and b) the miraculous healing, which also characterises charismatic communities in other national contexts (3). As far as the focal points of their ideology are concerned, it could be underlined the assertion that faith must be lived in a totalising way, as an experience that informs and qualifies the whole existence. It represents a bulwark against the spread of the evil forces working in a world that is perceived as negative, as essentially pervaded by the action of the devil. In other words, the charismatic experience connects the negative to concrete and historical human events and transposes it on a meta-historical horizon; it is no longer mere contingency, but becomes the fruit of the satanic action. Human action thus comes about in a meta-historical ambit and the world itself becomes the theatre for the eternal struggle between God and the devil (cf. Lanternari 1983, 1987; Cardamone and Schirripa 1997). This ideology naturally does not only characterise the charismatic. It can be found in a wider range of experiences from the folk Catholic world. As far as southern Italy is concerned, I would like to quote what Paolo Apolito wrote about one of Maria's apparitions in Southern Italy:

> «The visionary culture transposes on the symbolic ambit and remodels in the irrefutable mythical scheme of the gigantic and incessant struggle between God and Devil, the conflict felt between the unexpected, precarious and daily contingency (in the form of evil forces) and the desire for stability, safety and comfort. This is incarnate in the celestial powerful and eternal figures that are perceived as the only ones that can conquer the evil forces). Through a peculiar way of lived-narrated assimilation, a great collective narration builds the cosmic events of the apparitions, inserting in them in the crossways of their daily rhythm, in the symbolic constructions of the individual and the collective difficulties of the pilgrims and [...] all mankind. [...] Shaping the lived assign of other (the battle, the enemy, the Madonna), the possible has been re-captured, bent and explained as moment of a cosmic play which has a fixed end, the human history becomes sacred history. Even if in the human history the evil, in his daily intrusiveness, is not excluded; at least one can find a Meaning.» (Apolito, 1992: 165-166).

Miraculous healing, as I have already said about the ideology, is surely not only a characteristic of charismatic communities. In these communities, however, the miracle and the subsequent healing are part of a context that is completely different from the typical one of the religious folk therapies, on which many European ethnographic monographs focuses. Actually, in charismatic communities the miracle, and the healing that it produces, is inserted within a complex existential path centred on the conversion.

This conversion, moreover, is not to be considered only as an action for approaching – or re-approaching – the divinity. It implies the need to re-model existence itself around this new event: everything that happens in everyday life, such as the plans for the future, will from now onwards come under the new relationship established with the divine. It is in this context of radical existential change that one has to insert miraculous healing, which in this way sanctions the new relationship.

Healing is not interpreted only as the irruption of the divine into human contingency as happens in Roman Catholic tradition. On the contrary, it is introduced within a global re-reading of an afflicted existential path. In this context, illness and healing make sense in reference to the conversion. In the miraculous healing process that takes place within centre-stage charismatic contexts there are a patient and his long existential path. This is discussed and re-interpreted in the light of the radical change that the individual experiences through his conversion to the charismatic way of living the faith. The re-reading of the existential path of the convert imposes that the critical moments of his existence become its significant elements; and the discomforts suffered are underlined. The conversion will give meaning to those sufferings, and therefore allow one to free oneself from remembering "bad living". To quote a sentence by Giordana Charuty, charismatic therapy is often an action to «heal the memory» (4).

In these healing paths, then, individual bad living, as well as its physical sufferings, is nearly always identified with the demon's actions. In this case, a metaphor permeates the whole therapeutic process: individual evil is seen to correspond to Satan's action. Actually, in charismatic ideology, individual suffering bodies are the microcosm in which the eternal fight between the good, God, and the evil, Satan, is re-lived daily. If men suffer, it is due to the action of Satan; if they recover it is because of the intercession of the Holy Spirit, Jesus, the Madonna and the Saints. The body is the battleground between good and evil: if pain is the sign of Satan's action, healing is the sign of divine benevolence. The whole therapeutic process takes place – in this metaphor that brings the macrocosm – in which the eternal struggle between the divine and the demoniac occurs – near to the microcosm – the suffering body also perceived as the locus of that eternal struggle. It is in a sense that therapy frees people from bad living. Moreover, furthermore, it is this metaphor that gives new sense to the individual existential path. The pain people suffer can be interpreted as the consequence of the Devil's action, and in this way they become intelligible and interpretable to the individual. Recovery is not only liberation from evil, but also the sanction of an existential path that has conversion at its centre. In this way, miraculous healing also becomes meaningful to those who do not experience it personally. As a sign of the divine victory over the demoniac in the microcosm of a suffering body, it enables the divine cosmic victory to be predicted. This allows the believers who have not recovered to expound miraculous healing as the premonition of a greater reward: eternal salvation.

2. The community of Santa Domenica di Placanica

I would like to analyse here some specific issues concerning the charismatic movement of *Santa Domenica di Placanica*, its relationship with folk culture, and the subversive role of the body. I will discuss the research I carried out for many years (1989-1995), with Giuseppe Cardamone (psychiatrist), on the Catholic charismatic community of *Santa Domenica di Placanica* (Calabria, Southern Italy), better known as "community of the *Madonna* of the Scoglio" or more simply "community of the Scoglio" (5).

Santa Domenica is a small village in the Calabrese Mountains. It shares with the other settlements of this area a long history of depopulation due to migration towards foreign countries, the northern Italy or the nearby big cities, which are more comfortable and where there are greater opportunities for finding work. It is an area characterised by a depressed economy with a high rate of unemployment, chiefly among young people, and, as frequently happens in Calabria, the percentage of intellectual unemployment is very high.

Santa Domenica is not far from Serra San Bruno, where until the sixties there was an exorcist cult, known throughout the region, that has been analysed by Ernesto De Martino (1980 [1960]; Ceravolo 1999). The villages of Calabria are part of that southern Italy whose religious and cultural expressions De Martino interpreted as the limit of penetration of the hegemonic project of Catholic Church (6). From Serra San Bruno – and from many nearby villages, including some from the coast – thousands of people come to the hamlet twice a week, Wednesday and Saturday, to attend the worship held by the charismatic community. It is not unusual to find people from other areas of the region as well as people from other southern and central regions of Italy, especially in recent years when the cult has had a certain coverage in the mass media too. In each meeting people ask for healing and grace for themselves and their relatives, and during each meeting somebody claims that their wishes have been granted. Cosimo Fragomeni, known as Fratel Cosimo, is the leader of charismatic community (7). He is a layman. He is a leader with little formal education; his biography resembles that of many other visionaries. Books about his life history speak diffusely about the first time that Maria appeared to him, when he was in his teens (in the sixties), and about the first miracles that he was involved in. In his own land, Fratel Cosimo has built the church where the cult worships. For many years in that little church, then not consecrated, Fratel Cosimo – who was known to only a few people – received sick people and prayed for them to be cured. There were many *ex-voto* witnesses of healing cases in the seventies, but the cult began to be better known later, at the end of eighties. Then, for approximately 15 years, the thaumaturgic activity of Fratel Cosimo was almost unknown. What happened in the eighties to make the cult so popular? One of the first episodes that were important for the notoriety of the cult was the healing of a woman in 1988. This woman had been confined to a wheelchair since 1975. She attended the charismatic community for some months, then unexpectedly one evening – when she was before Cosimo – she got up and began to walk. The news was given extensive coverage in the local newspaper, but surely this alone could not justify the fame the cult acquired in a few short months. It was certainly not the first healing there, even if it was the most surprising. I think that the adhesion of Fratel Cosimo to the charismatic movement, about a year before that healing, was the main reason that the cult acquired the fame that it did. Actually, with this adhesion, his role changed completely: he was no longer a solitary thaumaturgist but the leader of a charismatic community that was quickly organised, attracting believers even from the villages of the coast.

3. Charismatism and folk culture

While I was studying the cult with Cardamone, we did not give Cosimo's adhesion to charismatism the importance it deserves. Today it seems to me that it is central to the whole issue. What changes does this adhesion bring about? How is Fratel Cosimo depicted in the books about him? Before his adhesion to charismatism his existential trajectory is similar to that of many other thaumaturgists raised in rural backgrounds: visions of the Madonna, the construction of a place of worship dedicated to her, miraculous healings, etc. He is, after all, a usual figure in the folk culture of this area (8). Before he joined charismatism, Fratel Cosimo had adhered to a model that was already known and diffused. The adhesion to the charismatic movement was a sharp break with this model. It marked a separation from some of the religious forms typical of the folk culture of this area. We do not know a great deal about the social origin of the people who approached Fratel

Cosimo in the seventies, but they were certainly people from the nearby villages, and shared with the thaumaturgist a long history of cultural marginality. If the social subjects whom he dealt with were marginal, also marginal were the folk models to which he adhered in those years. They are patterns that are in decline nowadays when new hegemonies impose new models, even on the level of religious expression. The limit of the cultural penetration of the Catholic hegemony, which Ernesto De Martino discussed in his works, has moved on to other forms and patterns. Folk magic, as well as folk Catholicism are slowly withdrawing in favour of other ways of magic-religious protection, which are often syncretistic or refer to forms such as orientalistic irrationalism, that arouses considerable interest in Italian society.

Joining the charismatic movement therefore gives Cosimo the chance of an alternative pattern. In particular it provides him with a cultural device that enables him to go beyond the narrow entourage of people that had addressed him up to that moment. In fact, the community that organised itself around him in the eighties – after he joined charismatism – is composite, from the cultural and social point of view. Undergraduate students stand side to side with farmers, people of rural extraction and individuals belonging to the professional middle class of the coastal towns. It is a variegated world also from the perspective of the believers' social biographies; individuals disappointed by their past experiences in the revolutionary and institutional left gather with people that have had considerable experience of militancy in Catholic organisations. So the success of the charismatician is not only due to thaumaturgical skill, but also – in my view – to the ability of having built a pattern that fits in better with the changed cultural context of the area.

At the community-worship meeting this variegated universe is clearly noticeable. A crowd that go there to worship, but above all to heal. The Scoglio in fact is chiefly the place where miraculous healing happens. From this point of view the pattern proposed by Fratel Cosimo, although consistent with charismatism, shares many elements with the folk culture of this area. Both physical and spiritual illnesses, in the charismatic view, are the sign of the devil's action. The sick body is a microcosm, which reflects the eternal struggle that, in a meta-historical horizon, opposes the divine to the malignant. Therefore, if illness is the sign of the devil, healing is the fruit of positive action by the Holy Spirit. In addition, the believers, in fact, invoke the Holy Spirit with Jesus and the Madonna, so that he descends on them to heal. The action of the devil is often interpreted in terms of possession, and the process of healing is viewed as an exorcism; to be performed it needs the Holy Spirit – with an endorcism – to descend into the afflicted. The possession paradigm and consequent exorcism are usual elements in Calabrian folk culture, and obviously in this area, where – as I said before – there were, and still are the vestiges of an important exorcist cult. Nevertheless, my aim here is not to show a repertoire of continuity and break-up elements that Cosimo's charismatic model has with regards to folk culture. This would be of dubious value. Rather I wish to emphasise how the continuities and persistence with the folk cultural world are inserted dynamically into the framework of the charismatic model proposed by Fratel Cosimo and how they give it coherence. At the same time these elements are fundamental for this model to be effective also in the rural areas where the traditional forms of religious expression still remain. The elements of continuity actually give the charismatic pattern a certain "family air". This pattern has succeeded in such different social and cultural groups because it is able to perform on two different levels: one of break-up and newness; the other of continuity and tradition.

4. Subversive bodies

I have said several times that people go to Scoglio above all to heal. In the believers' words, this healing can affect body and soul. I shall briefly describe the two most important moments of the healing ceremony: the first one is before the ceremony begins; the second in the final portion of it. The first is the meeting between patients and Fratel Cosimo. It is not easy to meet Fratel Cosimo; he actually meets only 100 patients before each ceremony. They have to book by telephone, and the "charismatic diary" is often overbooked. Fratel Cosimo spends one hour at these meetings. Therefore each patient meets the thaumaturgist for a very short period: between 30 seconds and a minute. In the brief encounter patients do not have time to give an exhaustive explanation of their problem, and the charismatician rarely replies. In one sense, meeting Fratel Cosimo is like having a relationship with the statue of a saint: there is no direct dialogue. Every patient briefly explains his own problem and begs for healing. The device is the awaiting of a miracle. At times, however, the charismatician speaks, or he makes contact with the person in a dream. In these cases the charismatician plays the role of supervisor of the physician's work, or more often that of antagonist, by imposing the interruption of the medical care and to seek healing through prayers alone.

The final portion is when Fratel Cosimo, at the end of the ceremony, invokes the Holy Spirit, Madonna and Jesus to heal people suffering in body and soul. It is a moment of considerable emotional intensity, and it is often possible to hear people shouting with joy because they believe that they have been touched by divine grace.

However, other things happen throughout the ceremony. This is something that characterises the Scoglio and about which people have spoken diffusely in the numerous rumours about Fratel Cosimo in all the villages and cities in the area. Various believers receive "physical healing" and many others fall into what is called – in the charismatic idiom – the "sleep of the Spirit", a quasi-catatonic state that sometimes lasts for several hours. For the charismatician, during the "sleep of the Spirit" the Holy Spirit works on the individual to strengthen his faith, but above all to heal the body or the soul. Many believers seek such an adorcism, because it is sign of healing and of having obtained the divine grace. Nevertheless, there are no techniques for inducing it, it is the Holy Spirit that chooses.

Other believers, instead, have extremely dramatic psychomotor crises, which the charismatician calls a "crisis of liberation". In this case the Holy Spirit works to free the individual from the devil that possesses him and the psychomotor crisis is the sign of the struggle between the divine and the devil inside his body (9).

The "crisis of liberation" and the "sleep of the spirit", then, are the two moments at which the presence of the Holy Spirit, and the struggle between him and the devil is, in the believers' interpretation, dramatically evident. They represent the moment that the body becomes a real "theatre" of the struggle between the divine and the demoniac, and its postures are, for the onlookers, external and visible signs of this struggle. Such crises follow a definite bodily code that makes them immediately comprehensible to the other believers at the ceremony. This shared code allows the body to narrate sufferings otherwise unexpressed. During the act of worship, in fact, the believers don't speak, they don't use words to communicate their sufferings to the assembly. Encouraged by Fratel Cosimo and his closer assistants they beg. Many of them are there because they hope to be healed, because they hope to interrupt a plot of suffering. However, this suffering cannot be listened to in the ceremony, there is no space for individuals to tell their story and what afflicts them. Their suffering is destined to be speechless. It is only at the end of the ceremony in fact that some believers have the privilege to speak. But the ones who speak, who have the opportunity to tell the others their own story, are not the people that at that time are suffering; on the contrary, those who speak are the ones who have recovered because of the miraculous action of the Holy Spirit. In this way the community of the Scoglio celebrates divine healing power, but it once more denies the believers the chance to share their own suffering, which is therefore shared only by means of the gestures and the postures of the body. The body grammar shared by the community somehow allows individual suffering to be collectively shared. «It is the body, the collectively shared grammar of his gestures, that makes explicit the contents of people in crisis experiences. It is the body that narrates the suffering» (Cardamone – Schirripa 1997: 175). As I have said they are gestures and postures that impress and worry and which people talk about a lot in the villages and in the cities to strengthen the supernatural character of what it happens at the Scoglio.

The body idiom I have briefly described here is often concealed in the ceremony. During the ceremony Fratel Cosimo often tells the believers not to take care of whoever is involved in "crisis of liberation" or "sleep of the spirit". It is the Holy Spirit – Cosimo says – that is working; the believers must pay attention to the liturgy. The body idiom – which outside the Scoglio is perceived as the sign of what happens there and as the sanction of the supernatural character of those events – has a marginal role during worship. The expression of the body cannot be central to the act of worship because its characters are irreducibly subversive. What Cosimo wants to conceal is the subversive position of the body that narrates its suffering.

The bodies that narrate their suffering break the orderly web of the charismatic cult. They allow divine healing action to become the central stage; at the same time they also permit suffering and bodily narrative to be at the centre. The body idiom also allows the expression of individual contents that are often subversive as regards the values professed by the charismatician.

It should be pointed out that during the ceremony charismaticians are inclined to put the elements of community that characterise their movement to the fore. They normally address each other as "brother" and "sister", they greet people with an embrace or a kiss, and often tend to meet at the Scoglio during the week for prayer meetings. They divide jobs and tasks and in general exalt a communitarian spirit to the detriment of anything individual. It is the community, not the individual, at the centre of their world. Referring to the believers' own sufferings through the body idiom means inserting elements of an individual/community dialectics, which break this scheme.

Moreover, even the contents that emerge from these gestures and postures are surely subversive with respect to the charismatic discourse. There is a collective grammar that makes the body idiom immediately comprehensible to the believers. Nevertheless, this collective *langue*, consistent with charismatic ideology, does not accomplish the body idiom. In it we discover a kind of individual *parole*, through which the bodies narrate their own sufferings, their own marginality and oppression (Corin 1980; Crapanzano 1977; Cardamone – Schirripa 1997). As Vincent Crapanzano (1977) points out, it is possible to retain possession as a cultural idiom that allows the individual to articulate his subjective experience. Therefore two aspects, which belong to every type of communicative event, can be singled out. We could say, like Corin (1980), that it is possible to assign to the body idiom, like other idioms, two different levels: that of the expression, which belongs above all to a collective ambit, and that of the meaning, which mainly concerns the individual.

Body expression is declined between these two levels and allows individuals to clearly show their own suffering, whose private content emerges in collectively shared models. Critical phenomena can in this way be inserted in a plot of meanings that allows individuals to place their own experience once again in a metahistorical horizon, which can give meaning to their own suffering. The level of the meaning, of the individual expression, finds a place in the endless variations of these stereotyped manifestations performed by the believers. The folds of these variations tell the story of each individual, and it carries out meanings that could be subversive with respect to the values of the community.

We have analysed elsewhere the idiom of these bodies, and the stories of suffering that they narrate (Cardamone – Schirripa 1994a, 1994b, 1997). They are frequently stories of women that use the body idiom of possession to express their silent rebellion to a condition of subalternity and marginality. During the "crisis of liberation", women with psychomotor crises often move in the ceremonial space shouting repeatedly: "no". They move excessively, and touch other people with their hands. In this way, they break the rules of the southern code of behaviour, and conform to a behaviour code consistent with demoniac possession. By means of the behaviour code of possession, they can demonstrate their rejection of the socially approved behavioural norms and at the same time, by touching the other believers, can ask for human contact, evidently lacking in their daily life. During these crises, other women perform explicit imitations of the sexual act, breaking at once with the charismatic ethic of chastity, but above all displaying an exasperated need of a sexuality that is still very often denied to the young women of many zones of southern Italy.

What I wish to assert here is exemplified by the story of a young believer, who I will call conventionally Ann, and who I have already analysed with Cardamone in another article (Cardamone – Schirripa 1997: 177-178).

Ann is twenty years old and lives in a hamlet not too far from S. Domenica. She lives with her family members – both parents and two older brothers – all of whom work as farmers. Apart from a short and failing experience of migration to Milan, with a consequent return home, Ann and her family have always lived in the same hamlet.

As a result of a family bereavement, Ann began to suffer from a series of health troubles and to behave so eccentrically that the family recognised in the signs and symptoms an attack of the malignant. For this reason, her parents and brothers led her to the Carthusian monks who live in a village nearby: Serra S. Bruno, which is renowned in the area for being exorcists. So, the journeys to the Chartreuse proved unfruitful; Ann didn't improve; on the contrary, organic illness was added to her troubles. She thus began an incessant wandering in search of a solution to her sufferings. Her family decided to consult medical doctors and psychiatrists and, in the meantime, they took her to the Scoglio.

After they joined the community, Ann and her family became the centre of the attention for many believers. The reason was the way Ann behaved (imitation of sexual acts, sudden lapses of consciousness alternating with clamorous episodes of excitement, shouts addressed to Cosimo and to the Madonna), and how she communicated a state of extreme suffering. She moved within the sacred space and spoke to other believers, touched them or frequently fell at their feet. Her unpredictable moves forced her brothers to protect her from the danger caused by her behaviour. Her gestures, postures and attitudes, though exasperating and embarrassing, were comprehensible within the community code. Ann went to the Scoglio because she was possessed by the devil and while she was there the Holy Spirit worked to free her. Her body became the theatre of the struggle between Satan and the Holy Spirit and her gestures and sufferings narrated the events of the clash to the believers. This is how the believers interpret what happens to Ann. The gap between Ann's behaviour and the believers' interpretation is not easily bridged. Ann still continues with her gestures and attitude, and the result is that the other believers tend to leave her in the margin of the sacred space. Her body is not easily tameable; her silent rebellion is not to be confined in the narrow border of the charismatic behavioural code. Her destiny, then, even in the context of charismatic worship, has been one of loneliness and marginality.

The values of the community of the Scoglio do not allow a body to express silent rebellion to the condition of woman, characterised by loneliness and subalternity, typical of the rural Southern Italy (10).

Like Anna, the bodies of the women attending the service express discomforts and messages that are far from the horizons of the believers and, therefore, unheeded. In this context, then, the body appears as an arena in which – through exhibitions and concealment – a struggle of meanings occurs. The rumours of lay people depend on the exhibition of bodies in crisis as proof that something miraculous is actually happening in Scoglio. Fratel Cosimo conceals the body idiom because it exceeds the boundaries of charismatic discourse. Cosimo and his collaborators would wish possession to consist only of the therapeutic action of the Holy Spirit. However, this is not so. Possession makes people release subversive contents, in a silent rebellion to a history of subalternity.

Notes

(1) Anthropologists have studied the spread of this phenomenon in various contexts. There are now numerous accounts on the charismatic movement in many different areas of the planet. For example the USA where the phenomenon has been broadly analyzed by Csordas (1983, 1987, 1994); or Brazil (Prandi 1997); for Europe see, for instance. Giordana Charuty's works on the charismatic movement in France (Charuty 1986, 1987, 1998 [1990]); for the Italian situation, see note 2.

(2) Cf. Cardamone – Schirripa (1990, 1994b); Ferrarotti , De Lutiis, Macioti, Catucci (1978); Frizzotti (1994); Lanternari (!983, 1987, 1994); Schirripa – Cardamone (1991, 1992); Villa (1994).

(3) Cf. for example Csordas (1983), and Charuty (1986, 1987).

(4) See Charuty (1987). On the same topic, see Csordas (1992).

(5) Cf. Cardamone – Schirripa (1990, 1991, 1994a, 1994b, 1997); Schirripa – Cardamone (1991, 1992, 1994).

(6) De Martino's work on Southern Italy is part of a broader debate, from the end of the 19th century to the 1970s, on the "Southern question". At the end of Italian political unification (1870), a large number of intellectuals and policy makers such as S. Sonnino, G. Salvemini, G. Fortunato, F. S. Nitti, F. Turati, N. Colajanni, L. Franchetti and others, debated the economic, social, "racial" and moral causes of Southern Italy's underdevelopment. After the Second World War, through Carlo Levi's novel *Cristo si è fermato a Eboli* (Levi 1949) and Gramsci's *Osservazioni sul folklore* and *La questione meridionale* (Gramsci 1950), which had considerable influence on the Italian anthropologists working "at home", the Southern question became one of the most prominent topics in anthropological debate. See Clemente – Meoni – Squillacciotti (1976); Pasquinelli (1977); Rauty (1976). For an English book devoted to this debate cf. Schneider (1998).

(7) For more about Fratel Cosimo's life see Prochilo (1989) and Turi (1995).

(8) See, for example, the Natuzza Evolo case (Lombardi Satriani – Meligrana 1982); about the traditional folk healers in Italy cf. Seppilli (1983, 1989).

(9) Although in his article Csordas (Csordas 1992) does not speak about the body postures related to these states, on the basis of the charismatic classification of kinds of healing, the ones I have described above are similar to the ones he refers to. He speaks about a «*physical healing* of bodily illness, *inner healing* of emotional illness and distress, and *deliverance* from the adverse effects of demons and evil spirit» (Csordas 1992: 280). In effect this classification can also be found in the charismatic movement I am speaking about. Csordas, refers to bodily healings; the "sleep of the Spirit" is the possibility to heal distress and emotional – that is to say: spiritual in charismatic language – illness (like "inner healing" for Csordas); and finally the "crisis of liberation", through which people can free themselves from demoniac influence or devil's possession (like "deliverance" for Csordas).

(10) Ann's body expresses the extreme loneliness of her condition as a woman and, at the same time, attempts to find an ambit of relationships that can contain all the ambiguity of her bodily displays. The expressive code of worship is not sufficient to exhaust the subversive position of her message, and it allows the protagonist to drift toward an ulterior marginality , as is shown by the epilogue of her story. About the female body and woman condition in southern Italy see Pandolfi (1992).

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 205-221

Gypsies: pentecostalism and health(1).

The Vie et Lumière Evangelical Church

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Introduction

This paper is part of a wider investigation that covers the articulation of all the health care practices that are customary nowadays among the Catalan gypsies of Perpignan (France). In particular, we should mention the scientific medical system, traditional medicine, self-medication and the healing practices of the Evangelical and Catholic churches. This article attempts to describe the reality of the health-sickness processes that occur within the Gypsy Pentecostal church called '*Vie et Lumière*', as well as the more common health care practices among the Catalan gypsies of Perpignan.

During 4 months of fieldwork in 1999, we carried out this study basically using the technique of observation-participation, together with interviews with gypsy women (our unit of analysis), and pastors, health workers (doctors, nurses, and pharmacists) and traditional therapists (2).

Vie et lumière

To illustrate the influence of the Pentecostal churches on the French gypsy population, the '*Mission Evangélique Tzigane*' first appeared in France in 1952, joining the French Protestant Federation in 1975, and it is thought to include approximately 60,000 believers, of whom about 35,000 have been baptised into the faith. Baubérot estimates that 'Assembly of God' is the denomination that congregates the greatest number of other Pentecostal churches in France (Baubérot 1993).

'*Vie et Lumière*', the name of the gypsy Pentecostal church in France, is the same congregation that is called '*Filadelfia*' in Spain, and both belong to the '*Assembly of God*'. The only difference between them is that whereas the first two are exclusively aimed at the gypsy population (all the participants are gypsies, as are the pastors and all the positions in the church hierarchy), the *'Assembly of God'* only includes the '*payos*' or non-gypsy population. This is the first time that this branch of the Evangelical church has given special treatment to a particular ethnic group.

Over a period of time, the gypsy Evangelical church spread from France to other countries, where healings and 'miracles' was the key to conversion. In his book *The Call of God to the Gypsy People*, Adolfo Giménez, a gypsy, says that the gypsies started to convert to Evangelism in France in 1950, and from there the cult spread to other countries, among them Spain, where it appeared only recently, in 1965. Around that date a group of seven Spanish gypsies, who had gone to work in France, converted to the Pentecostal church, returning home to preach the Gospels.

Pentecostalism and Health

Among the health care practices of the gypsy community, that of the Evangelical Pentecostal church is a question of faith healing, through the mediation of God, Jesus Christ and the Holy Ghost. The healings and 'miracles' that are produced in the context of ecclesiasticism, especially when they affect a family member, are among the main reasons for the adherence of the gypsy population to this religion.

At first, many of the gypsy believers were converted because they witnessed a 'miracle' cure, although nowadays it is possible to find believers who attend the church because they have grown up among Evangelists or, as one gypsy woman told us: «*I am an Evangelist by birth*».

When a member of the congregation has a serious illness they are prayed for in the church and presented before God. On these occasions, the pastor will act as a mediator, or channel, for this healing power, but it is possible, on occasions, that the sick people themselves or some member of their family will try to establish direct contact with the divine powers without the need of an intermediary.

They will often resort to doctors and divine power at the same time, or else they turn to God when the medical profession has given up on the sick person, and this is when the 'miracle' of a cure can happen.

The Evangelical gypsies have a strong belief in the efficiency of doctors, as they affirm, «*they are wise men that have been put here by God to cure*».

We can observe the lack of conflict between religion and medicine in one pastor's remarks:

> *«We are not against doctors (...) if it is a fatal illness, that's one thing. However, if you have a sore mouth, you go to the Doctor and he cures you. We are not fanatics. My wife has had a terrible cold since the start of the year and takes pills for it. God isn't curing her. I myself have asthma, diabetes, epilepsy and I go to the doctors. We know that the doctors cure. God is the great Doctor, but if God has given us wise men, we respect these men».*

Doctors, therefore, are respected and accepted in as much as it is accepted that they have been 'put here by God', and in the end it is the same divinity who gives them the power to cure. On the other hand, it's the seriousness of the illness that will determine the need to resort, or not, to the curative power that is attributed to the Holy Ghost.

'Testimonials' of faith healing are numerous among French gypsies, and the following account from a gypsy woman is just one example:

> *«My son had his heart all wrong, like the legs of an octopus, and I took him to the Doctor because he would go black. I told the Doctor what the matter was. The Doctor checked him over and said to my cousin that came with me: 'Look,* señora*, no.' I wasn't baptised. Moreover, he said to my cousin: 'This child isn't going to live, he is very sick and his heart is all wrong.' Afterwards, when I went to the church, we went to every meeting, my cousin says to me: 'Take the child to the church and present him, because he is very ill.' The baby was just a few months old then, very small. I told Berio (the pastor); 'The Doctor told me that my son is very sick, and that he has this, this and this.' And he said: 'Start praying and close your eyes.' I went into a corner and his wife was by my side. I had my eyes closed and his wife told me: 'Ask God for it, ask him for it, you'll see that he will give it to you'; and I asked God, I asked God and God gave it to me. I said, 'Lord, see how my son is, he will die because he has the heart not of a person but of a beast"; and when I finished praying, the servant of God told me once more: 'Give thanks to the Lord, give thanks to the Lord, that God has cured him for you'. I said:* 'Merci Lord, merci Lord'*, but didn't know why. And some days later I took him to the Doctor again and the Doctor told me: 'Listen,* señora*, this child isn't the same one you brought me.' Because I had health insurance for one of my children and didn't have any for the other one, and the first day that I took him, I took him in his own name and I paid; and the second time I took him with the insurance of the other one, under another name and he told me: 'This child isn't the one you brought me the other day, a week or two ago, because that child was very ill and this child has nothing wrong with him.' And he's now 35 years old».*

The structure of the 'testimonials' reproduces a model that is often repeated: there is a serious sickness that the doctors cannot cure, prayer is resorted to, with the mediation of the pastor between God and the sick person, and this produces the cure, the 'miracle'. The cure of the sick person reinforces the faiths of those that witnessed the 'miracle' and were not believers, and it is likely that both the sick person and their family convert to the church after this event.

On the other hand, the Evangelical church holds a great number of precepts that could be called preventative medicine; these include restrictions on alcohol, smoking, drugs and depression.

Sickness and its cure play a key role for the Evangelical gypsies in that it gives them the chance to justify their doctrine

At the same time, if the Pentecostals admit the validity of scientific medicine it is because they recognise that the Apostle Saint Luke was a Doctor: «*God put doctors in this world to attend the sick*». Faith healing forms part of day-to-day living for the members of this church. To this therapeutic representation, known as 'healing', is added another in which the Holy Ghost also participates: the 'miracle'. Nevertheless, apart from the 'miracle' and the 'healing', the cult emphasises other differences between 'healing' and 'salvation', the first referring to the body, and the second to the soul. To obtain salvation one must, therefore, accept the written words of the Gospels, abide by the established norms, believe in the Holy Ghost and, above all, undergo religious conversion.

The sicknesses they address

We could say that within the institution of the Evangelical church, treatment is available for every sickness, whatever its origin or nature. In the old days, the gypsies went to their own traditional therapists who dealt with the full repertory of common pathologies, and, depending on the seriousness of the sickness, they also went to doctors.

Although nowadays there is a big demand for standard medicine, in many cases they continue to use traditional medicine, which they call 'the old medicine'. Since the arrival of Evangelism among the gypsies a whole new therapeutic system has been established that gives an apparent solution to all those sicknesses that neither the traditional nor the scientific therapist could find an answer to, especially those considered 'very serious'. Even though the usual Catholic pilgrimages continued to Lourdes and Santa Sara, for example, where miraculous cures were often produced, Evangelism occupied its own sphere, attending new sicknesses among the gypsy population (such as drug addiction, HIV, etc.), but also helping and offering a solution to the sick for whom the scientific medical system had given up all hope. Thus began a new strategy that based the possibilities of healing and salvation on the power attributed to the Holy Ghost.

These circumstances caused obvious changes in the ways the processes of health-sickness-treatment were perceived, installing among the gypsies the possibility of a miracle cure, closer to them and more frequently occurring than the one offered by the Catholic religion.

The role of therapist in this new health care practice falls on the figure of the pastor. He does not replace the traditional therapist (in spite of the fact that he may use apparently similar techniques, such as the laying on of hands); rather he takes care of sicknesses or ailments that are basically different, from the simpler ones to the more complex.

Not all the pastors possess the same healing power, as they have different abilities as mediators. When the sicknesses are considered simple, prayer is the means by which relief or a solution to the ailment is requested. This can be done directly by the patient, without any need of intermediary action by the pastor.

Types of treatment

Evangelical medical practice presents us with two types of treatment, depending on whether it takes place in the public or private sphere, or whether these public or private treatments are for groups or individuals:

1. Group: This takes place inside the church. There may or may not be a direct relationship with the sick person. The mediation is established through a group of the faithful.
2. Individual: This takes place inside houses or hospitals or also during worship. There is a direct relationship between the pastor and the sick person, and the mediation can be carried out by the pastor or based on the ‘prayer’ of the patient himself.

1. In the case of group treatment, the ailment is exteriorised inside the church, and pronounced aloud in front of the believers. At the same time, the Pastor and the entire congregation pray in unison for the sick person. In this collective prayer, which calls on the healing power of the Holy Ghost, the faithful constitute the channel of mediation. It is not necessary for the sick person to be inside the building, as it is possible to petition on their behalf in their absence, or in the presence of one of their family members.

‘Missions’ may also be included within this type of treatment. That is to say, meetings that last for several days and where Pastors from other churches (be they from the same country or from abroad) also attend. These meetings are considered to possess ‘great healing power’ and group healing ceremonies take place. This form of group or collective treatment is different from all other types of treatment for health-sickness that are applied in the other medical practices of this gypsy community, not only those of the scientific medical system but also those of the traditional medical system, and is functionally adapted to the structural core of the gypsy culture, in which the conception of community constitutes one of the bases of social existence.

2. The second type, treatment that is effected in the private sphere, is personalised and the relationship pastor-sick person is a direct one, as the former becomes the mediator between the Holy Ghost and the patient. The most commonly used techniques in this practice are the laying on of hands and the anointing of oil. On occasions, the connection between the sick person and the healing power can be direct (without the brokerage of the pastor), and the mediating channel will be the 'prayer' offered up by the subject himself.

The treatment that is effected within this religious belief involves a continuous follow-up by the sick person. When a church member or some member of their family suffers an illness, the faithful will pray constantly for them to be healed and, at the same time, the pastors will regularly visit the sick. The care of the sick, the disabled and the old is highly valued in the gypsy community, and the whole family throws itself into it, although the women (above all, the mothers and grandmothers) are the ones who take care of the patients. As well as the care received from the family group, the faithful know that they can also call upon collective treatment from outside the private sphere that will effectively take place on the days of worship, within the church.

From these perspectives, we can distinguish between treatment that takes place in the family sphere and treatment that takes place in the religious sphere, both of which are sustained by biblical precepts and turned into acts of faith.

In the sphere of ritual, the most common therapeutic techniques are prayer, the lying on of hands and the ointment of oil. The laying on of hands is accompanied by the prayers of the pastor, and is usually effected in church; if the sick people cannot go there, the pastor will go to their home. Oil, which symbolises the Holy Ghost, tends to be anointed where the sickness is more serious; in these cases, a drop of oil is splashed on the patient's head, and prayer, too, accompanies this.

But the thing that will validate the act of healing, in both types of treatment, will be prayer as a concrete fact, being used as a therapeutic mechanism whose efficiency will depend on the repentance of the believer and on their faith, which is shared with their community.

Classification of sicknesses

The doctrine of the Evangelical church considers that only divine power has the capacity to cure sicknesses, not only those considered 'serious' but also the 'simple' ones. Much as doctors are thought to have been put here by God to cure, which allows for their consultation, when it comes down to it, the cure does not depend on the knowledge of the Doctor but rather on the decisions of the Holy Ghost. That is why it is common to ask God to guide the Doctor before consulting him.

For the Evangelical gypsies of Perpignan, 'simple' sicknesses are treated according to the problem, either at home or by seeing a Doctor. In Spain, on the contrary, we were able to witness the laying on of hands for relatively simple ailments, such as a headache.

In many cases more than one therapy is used, combining the laying on of hands with patent medicine.

The doctors can 'not' treat sicknesses that are considered 'serious' include all those that, and this is understood to mean that only God can cure them. It is at this moment when the family of the gypsy, be they believers or not, will call on the services of the Pastor, asking him for the laying on of hands and waiting for the 'miracle' to be produced.

In general, it could be said that the Evangelical gypsies group sicknesses, according to the possibilities of their treatment, into:

1. What the doctors cure
2. What the Holy Ghost cures

1. The former include all those that can be cured through patent medicine or through a simple operation, although the Doctor is considered to be merely a mediator between the healing power of God and the sick person.

2. The latter encompasses ailments that can only be treated effectively by the Holy Ghost, especially those for which scientific medicine has no answer. Among these last two variants are *sicknesses of the soul* and the *sicknesses of the body*.

Sicknesses of the soul refers to the intervention of the devil, as in the case of possessions, and are exemplified in this account by a pastor:

> «*One day they brought me a gypsy from Tolosa possessed, possessed, by the devil. He did things, said bad words, and swore by the dead. As a gypsy, he knows that you should never mention the dead. And they had him tied up; three ropes and he opened his mouth to bite us. The young pastors that were with me were afraid. I was sitting there. How can it be that we are afraid! And I say throw down the ropes...they say, 'no, no he's going to kill you' and I say, 'throw down the ropes' and he makes faces at me with his mouth like this.*» (He gesticulates).
>
> «*'What's your name?' and he made fun of me and said: 'Lucifer'. I said 'Leave in the name of Christ' and he fell down dead, and the spirit went out. I worked as an exorcist. Now I am old, you have to have lots of strength, because it can last ten days or hours and hours. You must be young and strong. The doctors are very wise but they are wrong when they see someone who is possessed and say that it is epilepsy. Because it looks the same, the same. The devil doesn't just want your body, he wants your soul, as he is jealous that you have happiness in God. So what does he do? He possesses you.*» (Pastor).

The sicknesses of the body, for their part, include all those sicknesses or physical ailments that have been treated fruitlessly by scientific medicine (cancer, HIV, drug addictions, etc.).

In both cases, the effectiveness of the treatment is associated with the will of the divine power. Evangelical gypsies understand that when the cure does not happen, it is because God has decided that the sick person and their family should go through this test, where they must demonstrate their faith. The very condition of being a believer puts the patient in the hands of a supernatural power, and this leads them to ignore normal measures for preventing illness, shifting the responsibilities and the solutions to the problem onto an external force: «*Even if you take preventative measures against certain illnesses*'– explains a gypsy woman –,'*if God wants you to get sick, you'll get sick and if God doesn't want anything to happen to you, nothing will happen*».

The diagnosis and prevention of sicknesses

Within 'Vie et Lumiere' Evangelism, the only therapist trained to be able to diagnose types of sickness and the possible means of healing them is the pastor, above all when it comes to those ailments considered to be of the soul. One of the most significant instances is that of possession, where the therapists who represent the two most important religions among the gypsies of Perpignan, the Catholic and the Evangelical, dispute the job of healing.

On the contrary, as far as the sicknesses of the body are concerned, the standard medicine practitioner is recognised as a person who has been trained through 'the power of God' to diagnose any illness, and in a certain way, the powers of traditional medicine and the therapists that practise it are denied. It could be said that the diagnoses made within this religion are for those sicknesses that are exclusively related to the Spirit and faith.

Prevention, on the other hand, does not exist in the traditional strategies of gypsy traditional medicine, but was introduced as one of the stronger elements of this religion. Prevention, (for the 'salvation' of the body as well as the soul) is based on the demand for a healthy lifestyle, without vices, addictions, stress or depressions that spare the faithful all those ailments that are shown to be the most common problems of this century. The model that the Pentecostal church proposes for spirit and the body transcends the sphere of the religious to reach not only the level of hygiene but also the social and political spheres.

Even though the prevention that Evangelism proposes has as its final objective the salvation of the souls of its believers, its influence in the processes of health-sickness-treatment is very important. Underlining the importance of 'the Word of God' and the fact that any ailment can be prevented with faith and conversion, the message aims to instil in the faithful the conviction that this way can put an end to the suffering caused by sickness or ailments of any type.

The differences between the prevention proposed by the hegemonic medical model (which follows the course marked out by sanitation policies, and more concretely by the specific programmes that are carried out in each neighbourhood or with each individual sick person) and by Pentecostalism, are to be found not so much in prohibitions and changes of habits, but rather in the consequences of the disobedience of such norms. Whereas in the scientific model the non-fulfilment of preventive actions can cause the patient to suffer a sickness without solution, in the Pentecostal church, simple repentance establishes an open door to healing, however serious the ailment may be.

The same occurs with the causes of sicknesses, that can be as much due to the sick person's wrong behaviour (what could be considered as divine punishment) or a trial of faith and spiritual strength. In the second case, any prevention is considered ineffective, as *«only God decides when one gets ill...»*

Often, the concept of prevention sustained by the doctrine of the church enters into contradiction with its own discourse as, on the one hand, it proposes special prevention for any type of sickness or ailment (based on conversion and faith), while on the another, it imposes positive behaviour to avoid sickness. Nevertheless, both seem to be in a certain way complementary, and respond to particular strategies for each social situation, based on fundamental preventive reasoning, centred on 'prayer' and 'fasting', two factors that favour communication with the supreme being.

Traditional Medicine

The coexistence of traditional medicine with other healthcare practices that take place within the community seems conflictive in some cases. Although, in this religion, standard medicine is accepted the same doesn't apply to traditional medicine; where the conflict is produced by the theory of the therapy.

The 'traditional medicine model' is modified by the Evangelical church's doctrine, which regards some of the techniques used in this practice as being against the commandments of God, and connected with the devil. Because of this, the traditional therapists can go from (in some cases) having a certain role and prestige within the community, to being considered subordinate to the hegemony of the new therapists, the pastors. At the same time their positive image is stigmatised.

Traditional medicine and all that is related to these ancestral forms of healing (whose repertory includes prayers to the saints, or some type of divination or contact with the occult) is called witchcraft by the gypsies. The church regards any type of witchcraft or ancient healing practices as diabolic, and for that reason is strongly persecuted. The Holy Ghost is considered the only power that can heal, prophesise, or perform miracles. Anything that is not done in the name of the Spirit is regarded as diabolic. The Evangelical Church's strict way of looking on traditional medicine frequently enters into contradiction with the gypsy faithful that have, until recently, been using their traditional therapists assiduously; and we still find that these therapists are the only ones that can cure a wide range of popular pathologies.

Some gypsy believers choose to obtain their cures through praying to God combined with seeing the Doctor. Other gypsy believers choose to continue with the traditional therapist for certain illnesses, as they are considered the right people for certain cures, above all for childhood ailments. However, they do not in the least consider that they are doing anything diabolical, they still tend to hide the fact that they are involved in these practices.

Drug addiction and addictions in the gypsy population

Drug addiction constitutes one of the processes of health-sickness treatment that is treated in a special way by this health care practice. In Perpignan, drugs began a to take hold among the gypsy population during the '80s, when many male gypsies started to consume drugs, basically heroin and cocaine. The Evangelical church produced a response to this ailment, which not only affected the sick people but also their immediate family and the gypsy community in general.

'Apart from affecting the family economy, the increase in 'drug addiction' emphasised the negative image of the gypsy in the majority society and generated episodes of domestic violence. The Evangelists took action in the form of the work of a neighbourhood pastor, who set out to be a companion to the drug addicts, putting it to them that faith was the only possible way to solve their addiction problems. In this way he managed to get some of them to give up drugs and become pastors or deacons. After the conversions of the first ex-drug addicts, especially after seeing the obvious change in them, members of the gypsy community began to accept that their husbands, fathers or brothers could cure their problem through the church. As the majority of the gypsy women in the city belonged to the church, many of them began a visit the temple to ask for help for their relatives who were drug addicts.

For the gypsy believers, drug addiction is regarded as, at the same time, a sickness of the soul, the morals, and the body, which can then go on to propitiate other ailments:

> *«To be a drug addict is to be sick both morally and in the soul, because why does a drug addict take drugs? He has problems at home, his mother and his father aren't together, and they have separated... many things. Others do it for pleasure, because that's the way it is, first one does it, then another.»*
>
> *«It is also a physical sickness because among them there are sick people. The first thing the drug addict gets is hepatitis C and so on. The least they can get is Hepatitis C and so on and so on.»*

Although the origin of the addiction comes, in the interpretation of the Evangelical gypsies, from the power of the devil and can only be cured with the addict's repentance and the healing power of the Spirit, the Pastors recognise that there are changes in the new generations.

> *«At eight, nine years of age they are smoking and all that, at fourteen, fifteen, sixteen, seventeen there is already a problem, but I notice* – relates a Pastor – *that with today's generation not all of them get involved in drugs, they go out with women, they smoke, they drink a little alcohol, but they aren't like before, like our generation».*

The incidence of this problem in the process of health-sickness-treatment has brought the church closer to a greater number of the faithful, who consider it a miracle when the addiction is cured. As with other aspects of the health issues associated with the church, a failure in the treatment is attributed to the bad will of the subject or the non-fulfilment of the church's precepts.

Although some addicts are treated with methadone through the official medical system, this treatment is believed to be no more use than a sticking plaster as the gypsy believers consider the only really effective solution to be conversion to Evangelism.

In the case of Perpignan, it would seem that other health care practices cannot address this problem, as it is not one of the common pathologies treated by traditional medicine, nor is it recognised by the church's therapeutic mechanisms as a treatment practice for the gypsy population. Some gypsies reaffirm this condition, from a point of the faith: «*The solution is God, for me it is God, for another it is methadone, for another it is to leave this world to go to find work*».

This public health problem has been so significant among the gypsies of Perpignan that the majority society regards the action of the *'Vie et Lumiére'* church as being almost exclusively to do with drugs, and the healing of drug addicts. Although in other Pentecostal denominations there is a special treatment consisting of disintoxication farms, in Perpignan there is a special religious service exclusively for young drug addicts, without farms, or any type of parallel attention on the part of the church during the rest of the time. Since 1992, the Monday service has been dedicated to adolescent male drug addicts, and nowadays the young people run it, generally the deacons and the candidates.

The present incumbent of these meetings is a young 29-year-old pastor who tells his story with these words:

> *«I have taken drugs, I came here when I was very much burdened with the things of the world. My father is a Servant of God. I came here; I heard the word and God touched me. In addition, from that day on I have not touched drugs any more, or alcohol, or anything. Most of the people who come here are into drugs, others take alcohol, coffee. There are different kinds: some on drink, others on drugs, others on the world...»*

The meetings for young drug addicts arose from the community's need to deal with a problem that was affecting the majority of the male gypsies in the neighbourhood. For the rest of the community, fundamentally for the mothers and wives, such gatherings represent hope of improving a health problem associated with the devil and the non-fulfilment of the norms and conduct expected of a gypsy man.

Conclusions

In spite of the fact that the ideology of the gypsy community is greatly influenced by Evangelism, the Pentecostal discourse does not come from within its own socio-cultural context; rather it is a religion that has been imported from and developed by Occidental culture. Nevertheless, the mediators are usually social actors from within their own community and, despite bearing an ideological discourse that is external to the group, they are incorporated into its very core. This makes them behave in a specific way and changes how they act as a group.

In the context of the wider society, Gypsy Evangelism is subordinate to the Catholic religion, which is also treated as hegemonic. However, in the context of the gypsy culture this new religion has abandoned its subordinate role to become hegemonic in its own right (while the Catholic religion has been displaced to a subordinate role within the group). Whether this phenomenon is apparent or not will depend on whether the analysis is macro or micro, or whether the object of study is the gypsy culture or the majority society. Thus, the same religion will be alternately hegemonic and subordinate.

If *ethnic identity* is the ideological form of the collective representations of an ethnic group, Perpignan gypsies ethnic identity has been modified by the incorporation of this new religion into its culture, as much in relationship with the majority society as within themselves. The new ways of living proposed by the Gospels and the Bible have made significant changes to their representations and practices, and in this context the Evangelical gypsies think of themselves as God's chosen people, the people of the biblical texts. Their function in this world has changed, therefore, from being a persecuted and stigmatised people to becoming a people for whom that stigma has become positive. It should be remembered that, according to Goffman, 'stigma' is a social process that does not separate groups and individuals, but rather roles of interaction.

The changes have come about in different spheres; group situations (image, customs, leaders, etc.) and in individual subjects. In this latter aspect, the subjects go from being despised or marginalised, as in the case of drug addicts or delinquents, to being respected by their community, even to the extent of becoming pastors.

Within the framework of the constructions that each social group elaborates to permit the reproduction of its own culture, the gypsy community of Perpignan is choosing its own course when it chooses its strategies in the processes of health-sickness-care. More than taking charge of the possibility of choosing gypsies takes on certain practices, such as those proposed by Evangelism. This way allows them to resist the pressures of the hegemonic society, but above all, of being able to choose those instances where they can find an immediate answer to their needs, are they pathological or sociocultural. Possibly it is this characteristic that is peculiar to Pentecostal churches (offering solutions and therapies for problems that other medicines cannot or will not address) which is the reason for the growing acceptance of this type of practices among the Catalan gypsies of Perpignan.

Notes

(1) Translated by Lesley Clarke

(2) After this 4-month stay with the Evangelical church in Perpignan, I carried out participant observation dureing a year (1997-98) in two Pentecostalist churches in Barcelona. The first one 'Filadelfia' (the name given to the gypsy Evangelical church in Spain), the second the 'Assembly of God'.

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 223-236

Politics of memory in 2001 Salento.

The re-invention of tarantism and the debate on its therapeutical value

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During the last ten years – and intensively the last five years – there has been a revitalisation of de Martino's thought in contemporary Italian anthropology and a parallel revitalisation of practices and discourses of "tarantism" in the local politics of culture and tradition in the Salento peninsula. This countryside is the part of Apulia home to "*tarantismo*", the spider bite possession ritual linked to the healing cult of Saint Paul, and location of the 1959 ethnographic study conducted by Ernesto de Martino and reported in his classic book, *La terra del rimorso* (The Land of Remorse, 1961). Forty years after its publication, this book can be considered as the prime example in Italy of an anthropology of illness "at home". *Las Indias de por acá* was the way de Martino called Salento, quoting the 17th-century Jesuit missionaries, and stressing the importance of an "endotic" field. Today several aspects characterise this process of revitalising practices and discourses concerning tarantism: the therapeutic value of "tarantism"; the use of the academic anthropological memory of de Martino on the local social, political, and cultural scene; the transformation of Ernesto de Martino into a symbol; the commodification of tarantism and, finally, its transformation into a sort of cultural capital. In this framework, the debate on the tarantism healing value takes the form of a conflict between those who still consider tarantism as a healing rite which, on the same track as de Martino, if not still visible, has not died but is concealed, and those who are bringing about the inversion of tarantism. Tarantism is no longer linked to social suffering but is on its way to becoming a "feast" and a public asset.

Politics of memory

In his article on the work of Ernesto de Martino (1908-1965), published in 1993 in *American Anthropologist*, George Saunders called de Martino "the founding father" of Italian anthropology and compared him to Claude Lévi-Strauss or Franz Boas, as «one of the most exciting, original and profound thinkers of 20th-century anthropology» (Saunders 1993: 865). The Italian debate on de Martino started up again, after quietening down in the eighties, in 1995. The 30th anniversary of de Martino's death was the occasion for an important conference on his work entitled "Ernesto de Martino within European culture", which provided the opportunity for a serious re-examination of de Martino's thought. At the same time, however, it was a true celebration of the memory of this founding father of Italian anthropology.

Now this bit of good fortune has led to another important consequence. De Martino is remembered not only by academic scholars, by several generations of Italian anthropologists, but he has at the same time been rediscovered by local actors in the cultural contexts in which he did his fieldwork in southern Italy. In the Salentine peninsula, the local public memory of tarantism is above all the memory of de Martino's fieldwork team, and the memory of de Martino's monographic studies. Depending on the different positions of the diverse subjects on the local scene, de Martino's work is at times the model for "correct" revitalisation practices, a sort of cultural map to be followed step by step by those who want to discover contemporary Salento, or a sort of guide to rediscovering places and people (de Martino's informants). However, he can also be considered as the anthropologist who has branded the Salentine peninsula with the term *Land of remorse*, which, for most actors of the local scene, is an offensive term synonymous with backwardness. So they say that Salento is no more the "Land of Remorse" – meaning the land of a "bad past" – but the "Land of Renaissance", and this transformation has been made possible by the continuous revision of tarantism studies. Another reason for this "renaissance" is that the cultural phenomenon he studied was really spectacular: a sort of spirit possession, a spider possession needing – as a therapy – dance and music. Tarantism is literally a "collective representation" in the true sense of a staged performance. Therefore, the academic rediscovery of de Martino's work seems to be paralleled by the Salentine rediscovery of his figure and the rise of several local anthropologies. At the same time there is a revitalisation and a reinvention of tarantism, which is being freed from its former aspect of suffering and despair, and transformed into a "renaissance" discourse, "renaissance" being the specific term used by many local cultural producers. The renaissance of tarantism is based on a rhetoric of nostalgia, above all for the original healing dance and music of tarantism: the rhythm of the *pizzica tarantata*.

The trance enigma: suffering or joy?

Recently Amalia Signorelli, an Italian cultural anthropologist who was part of the fieldwork team directed by de Martino in Salento in 1959, wrote a short note commenting on an article by a musical critic, Leonardo Nono. Reviewing a book by Gino Stefani, entitled *Intense emotions in music,* Nono wrote that the book was about "the vicissitudes of those who fall into a trance under the affect of tarantism, the phenomenon studied by Ernesto de Martino 40 years ago, in old Salento, *which unfortunately does not exist any more*". Upon reading this comment, Amalia Signorelli declares herself to have been struck by the expression "unfortunately". She says that she was "deeply bewildered, and indignant with Nono because she thinks it is simply abominable to think that «one could look back with regret on tarantism, on the practice of dancing the *taranta*, and lament its vanishing» (Signorelli, 1996, 591).

In Amalia Signorelli's opinion

> «As I saw it in fieldwork in 1959, tarantism was sodden with suffering, individual and collective suffering, it was drenched with 'psychological misery' and was associated in each case with a deep material indigence».

Here Signorelli is quoting the term that de Martino himself took from Piaget to define the roots of ritual in the psychological and material conditions of indigence. From our point of view, Signorelli's comment is very suggestive because it stresses the public use of de Martino's legacy. Although Signorelli's position derives from the same "engagement" which inspired de Martino's work – the hope that tarantism one day will no longer be necessary, that it will vanish when the subaltern class finally overcomes – she does not intend to criticise the "correctness" of the rereading of de Martino offered by this occasional commentator in the columns of Italy's leading newspaper, *La Repubblica*. The point of her comment is instead the way of transforming de Martino's thought simply by overturning his interpretation: the wish for the vanishing of tarantism has now been transformed into regret for its passing. The problem is to understand how knowledge about tarantism and Ernesto de Martino, the local knowledge which de Martino's book for the first time launched into the sphere of public debate, has now become circulating, shared information, a sort of belief or a symbol, which can be thought or acted out in practice.

The transformation of tarantism into a positive symbol, set free from its connection to suffering, is possible only because the symbol has been totally decontextualised, reified, and projected into an ill-defined universal dimension. While in de Martino's book the trance of tarantism is an example of a dramatic relationship between the existential self and its presence in the world (Pandolfi 1993), and the tarantistic ritual serves to solve this cultural drama, the contemporary public's rereading considers trance and possession by the tarantula as a cultural good, a public patrimony. The music and the dance are not linked any more to suffering but are the instruments for entering into trance, which is the main aim of the ritual.

This way of idealising and, at the same time, reifying tarantism and all related altered states of consciousness, ecstasy, spirit possession, dream and enthusiasm, whose objective is the motivation of emotions and the rediscovery of corporeal experience, constitutes the salient characteristic of the incorrect rereading of de Martino in the mass media and public communication, and the essential salient characteristic of the transformation of tarantism into an outright cultural good. Furthermore, the ritual nature of the phenomenon of possession favours its representation as objectified, naturalised, and embodied historical memory. The reversal of de Martino's interpretation of tarantism is thus inserted in the anthropological debate concerning the exorcistic or adorcistic nature of tarantistic ritual, and accepts the criticisms levelled at de Martino by scholars including George Lapassade (1994) and Gilbert Rouget (1980), who accused him of not seeing tarantism as a true cult of possession, but merely as an exorcistic ritual. These adorcistic academic interpretations thus favour the local revitalisation reinterpretations. The search for possession becomes a sort of attempt to enter into contact with the past, to renew the past in the present through a practice of nostalgia (Battaglia 1995).

This rereading of tarantism is clearly evident in the new literature on the subject, which has been evolving in the Salento area over the last ten years, and with particular intensity over the last five years (Pizza 1999). Here we are confronted with the problem of the interweaving of the academic anthropological debate and the anthropological memory of de Martino, a literary sociology of the local reception of de Martino's work, and the cultural policies being put into operation in contemporary Salento which are revitalising and activating the memory of de Martino and tarantism.

Tarantism as "love bite" or as "rebirth"

I will now examine two figures that represent different approaches to the phenomenon of tarantism and to its healing value, as well as different ways of representing its historical continuity: the link between tarantism and suffering and that between tarantism and joy. This historical continuity should be understood as continuity with the Salentine "past" – defined broadly as the "origins of tarantism" – but also as continuity or discontinuity, according to the various positions, with de Martino's treatment of tarantism, assumed as a model for memorialising Apulian tarantism which one may subscribe to or reject. The books written by these authors all take de Martino's text as their fundamental model, often even imitating its style and composition with its photographic appendices and selection of sheet music, and are sometimes sold together with audio or video cassettes. One common horizon is a narrative expressing a sense of belonging to the place and dedication to the memory of the past. We are dealing with local insiders in the contemporary practice of Salentine tarantism who are also involved in the field of Salentine cultural politics both as organisers of traditional events and programs and as performers, leaders of musical groups inspired by the musical tradition of tarantism.

Luigi Chiriatti is the leader of the popular music group called *Aramirè*, and the author of a book on tarantism called *Morso d'amore* (Love Bite). In Salento, Chiriatti has been one of the chief operators in a program of rediscovery and conservation of tarantism, with a style that is rather averse to "contamination." Recounting the story of his life, he defines his "entrance" into tarantism as an "initiation crisis," stealing from anthropology concepts and terminology to explain his own choices. Sometimes he chooses the style of an illness narrative, a rhetoric of a suffering cured after his entrance into the world of tarantism. It seems that his body, the body of the writer, is "in pain" (Fabre 1998). The volume opens, in fact, with an evocation of the author's own childhood in which cruel games with animals – snakes, lizards, spiders – which are characteristic of the folklore of children's games in the rural Italian south – are experienced with a sense of guilt, especially with respect to Saint Paul, the saint who is both the agent of possession in the tarantistic ritual and the guarantor of the cure. His precocious attraction for the observance of the popular traditions of his local community – starting when he was ten years old and continuing up to a university thesis on tarantism – is recounted and interpreted in this book as a sort of vocation which grew out of the family environment. He begins by recording his parents' singing and then journeys around Salento.

From this moment on, his research on local tarantism, which will lead to encounters with numerous "*tarantate*," is described as a kind of challenge-dialogue between himself and Saint Paul, a dialogue similar to the ritual one between "*tarantati*" and the spirit that possesses them. It is an encounter between two double ambiguities: Chiriatti the researcher and Salentino, the Saint Paul who heals the bite but who bites (the agent of possession who is also responsible for the cure). Chiriatti describes his research on tarantism as a continuous attempt to escape from the possibility that he too will be possessed by the spider-saint. Therefore, he decides to continue his study of tarantism through the vehicle of his university thesis, but here too his approach is much more cautious, much less morbid than other ones (Di Lecce 1994). He assumes an attitude of greater modesty in following the Demartinian tracks, in contacting the same informants. So in the early 1980s, when he takes up his research once again, at the beginning of a process of revitalising theatrical performances of tarantism, he starts shooting a new documentary and discovers a new tarantata, Cristina, who will be his Maria di Nardò (the main "character" of de Martino's monograph). But, in Chiriatti's account, it happens that, at the moment she is about to be filmed, the tarantata doesn't want to dance, she doesn't feel, that is, the impulse of the trance performance, and it is then that he reactivates his competitive dialogue with the saint, has a vision, more or less real, of a snake, and kills it while yelling out the traditional magic chant which he had used as a child to challenge Saint Paul. Struck by the challenge, the saint-tarantula moves inside the body of his tarantata, so that the filming of the dance can begin. As we can see from this account, the phenomenon of tarantism is reconstructed in the expressive form of a story of memory, but the attempt to objectify tarantism is an ongoing challenge for Chiriatti, a real and true example of exorcism. The acts he performs in his study of tarantism are efficient only when he succeeds in winning his intimate challenge with the saint, as he is also "inside" the local tradition, an "initiate," as he defines himself:

> «The state of being inside the phenomenon as an active participant comes out anyway when I play the drum. During my performance of the *pizzica tarantata* there are moments when I completely lose all sense of reality and I enter, if only in a personal way, into another reality made up of sensations, emotions. [...] Perhaps it is this inside-outside freedom to go in or come out that gives rise to the conflict between myself and Saint Paul: the fact that I have not been captured by him, that I am not one of his possessed, has put us into conflict, sometimes dormant and sometimes diluted over time, but never resolved» (Chiriatti 1995: 21-22).

It is quite evident from the account that the concepts of "native" anthropology and the references to de Martino are utilised to achieve a re-evocation-reinvention of his own cultural memory. Outside Salento, in New York, the metaphor of "love bite" concerning the therapeutical value of tarantism is acted in musical and healing practices by Alessandra Belloni, who is a singer, percussionist, actress and dancer who works in the U.S.A. with her group of players "I Giullari di Piazza. I will analyse the case of Belloni in a forthcoming article. What I want to recall now is only that she teaches the frame drum in international schools of music-therapy and as a cultural producer she is engaged in an attempt to transform tarantism into a sort of "new age" religious and healing cult (Consolmagno 1999).

Tarantismo e rinascita (Tarantism and rebirth) is the title of a volume published recently by Pierpaolo de Giorgi (1999), an author of whom the book jacket states:

> «Pierpaolo Giorgi took his degree in Philosophy at the University of Perugia, discussing a thesis in Aesthetics. He is currently the director of the regional centre for educational and cultural services in Copertino. He conducts intensive activity of research and promotion of cultural initiatives in the area of popular traditions and ethnomusicology. His interest in the practice of the performing arts led to his founding the group of "*Tamburellisti di Torre Paduli*", with whom he has gone on concert tours throughout Italy and abroad. The group's musical activities are aimed at the conservation and promotion of a whole tradition of Salentine music and dance, commonly known as "pizzica, pizzica". With this volume he wishes to share with the public a broad range of his reflections on various aspects which come together to make up the universe of tarantism».

«This book... is me», began De Giorgi, at the presentation of his book in Perugia, a city in central Italy, before an audience composed primarily of people belonging to the Salentine community of Perugia. He thus rendered explicit the intimate motivation which pushed him to write the book: the attempt to find in tarantism an "ancient identity," both individual and collective. This is also how he explains the book's title. It is a title, which expresses, through the idea of rebirth, a reversal of the Demartinian concept of a tarantism connected with suffering. In a perspective which historians of religion would define as neo-irrationalist, De Giorgi attempts to subvert that which to him is a stereotype of a tarantism connected to individual and collective suffering, to arrive at an understanding of the archaic dimension of tarantism, rooted in the archaic mythologies of *Magna Grecia*. In regard to this point, we should bear in mind the broad range of De Giorgi's activities. He is a poet, a musician in a neo-tarantist ensemble, who defines him as an ethnomusicologist and anthropologist who is employed in a cultural institution in the Salentine town of Copertino. He is among the most important figures in the contemporary movement for the revitalisation of tarantism. As he himself proudly states, his objective «is that of protecting and recovering the Salentine heritage and in particular the culture of tarantism. The music that cured the *tarantate* must now enchant the crowds in the piazzas». Tarantism is dying in its canonical, Demartinian forms, but according to De Giorgi

> «it is being born again, because it is nothing else but a philosophy of rebirth, a definitive resource for survival» (De Giorgi 1999: 47).

Therefore, from his perspective, the southern question becomes the question of the rebirth of forgotten folklore:

> «Having shed the worn out clothes of cultural subjection, the Apulian folk tradition and more generally the Mediterranean folk tradition now appears in all of its exuberant potential for rebirth» (Idem: 51).

Images: the inversion of tradition

Now I would like to examine, very briefly, three examples of multimedia expression of the aesthetics of contemporary tarantism – the case of a painter, that of a photographer, and that of a director, all three Salentines who have achieved international success: the painter Luigi Caiuli, the photographer Fernando Bevilacqua, and the director Edoardo Winspeare.

The painter Luigi Caiuli recently donated to the town of Galatina – home of the Church of Saint Paul where the ritual of tarantism takes place – a collection of his paintings constituting a real and true cycle called *Le tarantate di Luigi Caiuli*. The cycle is composed of «twenty paintings, oil on canvas, representing stories of tarantate», as described by the town administration. These paintings were shown in 1998 on the occasion of an international conference organised by the scholar Gino Leonardo Di Mitri, a high school teacher in Maglie, a town in Salento, and supported and promoted by the Municipality of Galatina, by the regional administration of Apulia, and by the University of Lecce, and which was attended by a large number of academics and local historians. The conference was called *Tarantism: Forty Years After De Martino* and had, through the publication of the proceedings, the clear intention of going beyond the Demartinian thesis to achieve a substantially local reappropriation of the phenomenon and above all of its "official interpretation". Reprinted in the appendix to the proceedings of the conference, Caiuli's canvasses are introduced by the following presentation:

> «The tarantate by Luigi Caiuli are the fruit of a twenty-year study which brings together the various themes of the painter such as society, peasant culture, and the historic folklore of Salento. His work is aimed, therefore, at

> bringing to light all that which has come out of tarantism and moved into the realm of myth and legend. Luigi Caiuli's objective in donating these twenty paintings to the town of Galatina is that of not dispersing what could be defined as an artistic-cultural patrimony and to offer to future generations the visual documentation of a part of Galatina history which has been gradually losing its place in local memory» (Di Mitri ed. 1999: tomo II).

This cultural and patrimonial reading proposed here takes the place of an aesthetic interpretation. It is not possible to conduct an in-depth analysis here of the paintings and of the context in which they were produced, but even a superficial look at them reveals their connection to the Demartinian and post-Demartinian models of visual documentation, further radicalised in the erotic representations of the tarantate, in those corporeal figures of the possessed that her family members, during the possession rite, try to keep hidden from the eyes of observers, and which represent the "non visible" part of the ritual. Even the titles of the paintings recall expressions coined by de Martino: «fury and stupor; erotic fury; dance epidemic; domestic therapy; music therapy; the spider women etc.».

Along the same lines as Caiuli, and as part of a cultural program organised by the Galatina Fair entitled *Tarantati*, the photographer Fernando Bevilacqua, set up a show called "an uncontrollable desire to dance" which he defined as a documentation of "neotarantism" with the objective of «demonstrating the euphoria tied to the new phenomenon of the Salentine pizzica now so popular among young people». He also presented a musical video-clip entitled "Bit, pressed together in space without time" in which he states:

> «It was necessary to give some dignity to the phenomenon of the tarantate that was different from the historical documentaries. It's a real music video created on the computer which explains what the poet Antonio Verri called the "long hiss," the close relationship that exists between the Salentine people and their land because today young people are consciously trying to recover their traditions. They play music and dance to achieve the joyful state of the trance. The taranta which instilled fear and was damned is coming back to the younger generation in the form of a joyous state of grace».

The inversion of the tradition (Thomas 1992) here could not be more evident. Bevilacqua was born in the Salentine town of Muro Leccese, where he was the town photographer, and now, by way of so-called neo-tarantism, he is able to sell his products in the main global markets of culture, even in Los Angeles. For this reason his neo-tarantism has an unequivocal positive sense. Furthermore, the phenomenon's close ties to the local community are used as a sign of authenticity that guarantees the typical nature of the cultural goods it produces.

This is also the case in the world of cinema. Apart from the creative and aesthetic values of these products, they have taken on the characteristics of cultural goods whose connection to the local community, whose "typicality" appears to be founded on the capacity they have to adhere to representations of local history and at the same time to project themselves into the global dimension of the market. This is the case of the director E. Winspeare, another Salentino, despite his odd-sounding name. His first film *Pizzicata*, from 1994, is constructed around a radical manipulation and transformation of the story of Maria di Nardò, the true foundation myth of the cult of de Martino. As has been observed by Georges Lapassade – one of the anthropologists closest to and responsible for this mediation between local discourse and anthropological discourse – «de Martino's work provides the basis for cultural construction, which then follows from it. As if it were a permanent support for the *pizzica* which resists by way of its elaboration in folklore, a sort of *trait d'union* between past and present» (Lapassade 1995: 12; 1994). In 2000 Winspeare's second film on Salento was released, *Sangue vivo* (Live blood), which was warmly received by the critics. The film is the story of two "pizzica" musicians, one a smuggler and the other a drug addict, who, as the critic Mario Sesti has written,

> «confront each other openly on the arbitrary boundary between opposing views of life. A struggle for survival which moves between the risks of dissolution and the possibility of breaking through, in this umpteenth updated variation on *La terra del rimorso*, whose presence is felt in the suffocating, sun-baked landscapes, in which only music seems capable of relieving people's pain. A substantially immobile world, in which the protagonists never succeed in escaping their destinies of self-destruction, the women never manage to overcome their look of pain» (Sesti 2000).

Tarantism seems to have returned once again to its representation of illness and suffering, or the incarnate critique of hegemony. One is surprised, therefore, to hear the rhetoric of nostalgia, which creeps in to the interviews of the Salentine director. After the success of his films, Winspeare is being used to promote Salentine products and has given a series of long interviews where he talks about typical Salentine dishes and the attractive qualities of the local cuisine.

Tarantism today

If we move toward a more open interpretation of tarantism as spirit possession, we can consider it as a wider system of thought and practice to which local writings, pictures, films or music performances also belong (Boddy 1994; Pizza 1996, 1999; Lambek 1999). As we have seen, the books about tarantism by Chiriatti and De Giorgi cannot be considered to be the work of local historians, but they must be seen in conjunction with their activities as musicians, writers and artists. At the same time, they participate in the ritual healing performances of tarantism which are still put on in some local communities. What the works of these authors have in common is the "search for origins", which is especially strong in De Giorgi. Their search does not constitute an anthropological or historiographical problem but belongs, along with De Giorgi's other creative practices, to a complex rhetoric of identity and self, which attempts to effect a ritualised rebirth of history in the present (Boyer 1996; Lambek 1999; Csordas 1999), or rather to ensure the continuity of the past in the present by reincarnating it in the physical performances of dance and music, or by identifying a new symbolic life in a system of objects connected to tarantism, and in particular the drum, which, as happens in the hyper-symbolising mechanisms present in Western practices of neo-shamanism, is described as a cosmic instrument. De Giorgi writes:

> «In my view the Salentine drum is a perfect symbolic expression of the contemporaneous presence of complementary opposites (the sharp notes of the rattles and the bass notes of the skin) condensed inside the unity of the magic ritual circle of the frame. More precisely, it is the instrument that allows the union of sky and earth, the sacrifice and the construction with the skin of the goat, the quintessential sacrificial animal» (De Giorgi 1999: 159).

Chiriatti writes:

> «The drum is the most important instrument for the musical therapy of the *tarantati* and it must be made in a certain way because it represents the synthesis of musical therapy and is itself a synthesis of symbols. Circle, rattles, and skin must be assembled in a certain way […] The circle represents, in its roundness, the universe and the magical-ritual circle in which the action of the ritual takes place. The rattles, always made of copper, represent disorder, the irrational, the obscure, the ugly, the discordant, reality that scratches you and falls on top of you. The rattles scratch, cause disturbance, refuse to enter into harmony with the other instruments, they are annoying, in discord with the pre-constituted rhythmic and harmonic order. This is the reason why the old musicians don't appreciate the new drums with small, harmonious rattles. The skin represents the constant rhythm, the constant cadenced beat, which serves to reintegrate the taranta into the order of the things of daily life» (Chiriatti 1995: 27).

The "fetishist" symbolism of the drum is thus revitalised by local subjects in complicity with the neo-irrationalist and Jungian readings, which are proposed, often in the prefaces to books by academic philosophers and scholars. These academic professionals tend to deconstruct, on a scientific level, the Demartinian interpretation of tarantism, almost as if they want to liberate it from the interpretative anthropological hegemony of Demartinian studies, obviously more attentive to the symbolic effectiveness and to historic-cultural contextualisation of symbols, and far from any idea of proposing "incentives" for their revitalisation. On the other hand, the neo-mythological and neo-irrationalist perspective lends itself well to the essentialist construction of identity and belonging and a cultural politics, which transforms tarantism into a saleable good capable of being projected onto the global market.

To study contemporary tarantism today means coming to terms with this complex interweaving which brings together various kinds of practices – writing, art, cinema, philosophical reflection, academic anthropology and cultural politics – put into play by local institutions. The actors in this complex field of discourses and practices appear to be organised in a sort of complicity which is manifested, on the one hand, through a certain contemplative rhetoric, based on the search for the "origins" of local culture and thus consciously intent on the reinvention and revitalisation of tarantism, and, on the other, by the embodiment of traditional knowledge through the performance of the metaphors of tarantism and through their naturalisation in daily practice. The complex ritual of tarantism offers itself as a complex device for the embodiment of these imaginative processes and it allows a rhetoric of identity to be created which simultaneously models and constructs its own sense of self. Anthropology has by now completely entered this process, offering the instruments that enable identity politics, its conception, objectification, and finally, its incarnation. Ernesto de Martino is transformed into an embodied symbol, to be recalled or rejected, evoked or repressed. Basically he has now become identified with Saint Paul as the guiding spirit both for anthropologists and local experts; he is the agent – and in this role, yes, ambiguous and ironic just like any self-respecting spirit – of a new form of possession, adorcisitc and exorcistic. Or rather of a process of incorporation of local history and local memory, a complex process, which delineates a field managed by a multiform variety of social actors and micropowers, now in alliance, now at odds. A real and true division of labour is at work. This division of labour derives its structure from tacit or declared complicity between local, academic, and national authorities and institutions, and cultural operators and specialists in local culture, or can explode into open conflicts that take the form of discussions about the "purity", the "authenticity", or the "correctness" of the tradition.

In sum, what is being put into play is a politics of memory and tradition, which lets the memory of healing ritual interact with the identity politics (Csordas 1999) and the "visible evidence" (Mahon 2000) of practices and discourses of cultural producers. This process involves anthropologists and anthropology, and that is why it is a challenge for fieldwork, because it is leading us to reflect about our involvement in the realities, which we study. When anthropology is at home (Peirano 1998) anthropologists should be more aware of their own "aptitude" for complicity with local politico-cultural processes of imagining the past and reinventing identity.

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Introduction

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The third section on the liturgy of health and health care consists of a collection of four papers dealing with science, medicine and religion, rituals and magic, transformations and narratives in hospitals and community health care. While the concept of liturgy is presented in only two of the papers, the significance of liturgy, in the sense of rituals conducted according to prescribed rules, is a central theme in all the papers. The performative character of medical practices, through which essential features of Western culture are mediated, and the religious character of the questions posed in situations of matters of life and death is highlighted. As argued by Sjaak van der Geest in his discussion of magic, science and religion, the demarcations between the rational and the irrational are blurred even in the clinical settings, which we tend to think of as dominated by hard core science. With references to anthropological classics such as Malinowski's work on magic, science and religion and Geertz' definition of religion, Sjaak van der Geest suggests that we look at doctors as religious practitioners and at hospitals as secular churches where people perform acts and express their beliefs in science and biomedicine as ultimate truth.

Josep Comelles starts this section with a very personal presentation concerning the process of treatment, rehabilitation, and recovery from burns that were brought on his wife after a serious car accident. The account draws on the story of Orpheus and his struggle to save his beloved Euridice from the underworld and is partly based on diary notes. As an example of auto-ethnography, written from a position 'at home' in the strictest sense of the word, the paper demonstrates the strength of personal narrative as a tool for grasping the reality of human suffering and misery as experience with a minimum of interpretative distance. The marginal and sometimes liminal position as a relative of a patient in the world of hospital regulations and routines, and the difficulties of handling the uncertainties of life and death by professionals as well as patients and relatives is described with a moving sense of reality. The painful question of whom will have the resistance to 'pull through' and who will not becomes the turning point of all communication.

Even though hospitals are institutions full of uncertainties, they are also places where miracles can take place and where hope is expressed through symbolic ritual techniques. Magic provides meaning to existence, and though conventional religion may be disappearing in our societies, there is still belief in truth and the miracles of biomedicine. Juha Soivio supports the idea of hospitals as important markers of culture by viewing hospitalisation as a rite of passage through which cultural values and norms are communicated in an effort to transform the patient from one status to another. His research on the treatment of coronary heart disease in a Finnish hospital shows, however, that in practice this is not always an easy task. Patients are pragmatic creatures and the emphases on psychological and lifestyle adjustments in the rehabilitation programmes often seem to collide with the habits of everyday life. While transformation is expected to be an outcome of the patients' flow through the hospital, another and more static aspect of ritual applies to the bureaucratic organisation of hospitals as institutions. Ceremonial order provides stability and structure thus assuring that essential messages and technological control are inscribed directly into the bodies and lives of the ritual subjects.

The mad stories told by Els van Dongen from a closed ward of a Dutch mental hospital also show how manipulation through ritual and magic becomes a means of control. People are 'walking stories'; they narrate and live their narrations. Magic is an integrated part of these stories. In an effort to de-pathologise such stories van Dongen points to the work of culture through madness, and the work with culture in the stories as rituals to control powers of madness and the health system that lie beyond the control of the patients. She also shows, however, that there are limits to the understanding of and coping with 'the differences within'.

The disenchantment and re-enchantment of modern society is one of the subjects that are raised by these papers. By insisting on the use of concepts such as liturgy, ritual, magic, and religion in the analysis of hospitals, medical anthropology at home is contributing to a re-enchantment of modern society (see closing keynote of the second meeting, Els van Dongen), but we should perhaps remind ourselves; that the danger of exoticising human suffering and medical practices is just as present in studies at home as in studies abroad. The ethnographic preference for the strange, the spectacular, and the extraordinary may well overshadow the ordinariness of quotidian life. Is liturgy a useful concept for medical anthropology at home and more specifically for the analysis of the activities that take place in hospitals or community care? In the sense that it explicitly or implicitly highlights the performative and religious aspects of medical practice and the work of culture, the papers presented in this section show a richness of potential.

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Hospital care as liturgy: reconsidering magic, science and religion

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In his essay *Magic, science and religion*, Malinowski (1948) discusses the resemblances and differences of these three concepts. He spends most effort on the differences. For Malinowski, science is empirical knowledge based on people's acquaintance with the environment, allowing them to use the forces of nature. Religion is faith in the supernatural world, embodied and maintained by rituals. It establishes and expresses valuable mental attitudes such as reverence for tradition, harmony with the environment and the acceptance of prospect of death. Magic is a practical art, a symbolic ritual technique that brings about what cannot be achieved by 'ordinary' techniques. Science is rooted in logic and experience, religion in emotional stress and anxiety, magic in hope.

These distinctions between magic, science and religion confirmed most readers' self-perception at the time. Science has nothing to do with religion; science is verifiable knowledge, religion is faith. A scientist can have a religious faith, as, in his view, religion does not interfere with science. Magic is a primitive kind of science, not based on empirical knowledge but on the "sublime folly of hope." Traces of magical thinking may also be found in Western society, but strictly speaking they should not be there. A scientist may be religious; but he does not believe in magic.

This essay has been written to blur the old demarcations between magic, science and religion. I will argue that from an anthropological point of view the three are but facets of one social and cultural reality. The concepts have fallen victim to a dichotomist worldview in which subject is posed against object, spirit against body, rational against emotional. In everyday experience, however, magic, science and religion are difficult to distinguish. This is particularly true in clinical settings, which are commonly believed to be the hard core of scientific acting. I invite the reader to look at clinical work with other eyes: as occasions for religious emotion and hopeful magic.

In his introduction to Malinowski's essay, Redfield (1948, 9) speaks of the «warm reality of human living» and the «cool abstractions of science.» My purpose is to argue that there is 'warmth' in the scientific achievements carried out in modern clinical settings and that the opposition of science to faith and emotion and of technical rationality to ritual hinders the anthropological understanding of clinical efficacy.

Magic, science and religion

Magic and biomedicine

'Magic' has been considered a derogatory term. Tylor (1871) called it «one of the most pernicious delusions that ever vexed mankind» (cited by Stevens 1996: 721) and a "hurtful superstition". Frazer named magic "bastard science" and "pseudo-science". In their views, magic shares with science the objective of controlling the forces of nature, but it is at the same time the opposite of science because it is mistaken, based on wrong assumptions about the working of nature. Early anthropological accounts of magic were primarily negative definitions of science. 'Magic' proved a useful concept to depict Western thought as superior to that of others.

Malinowski (1922, 1948) has attempted to give magic more credit and recognition. He turned away from Frazer's view of 'wrong science'. Magic is less irrational than we think, Malinowski argued. People are continuously confronted with the boundaries of their ability to bring about facts. In their uncertainty about the final result of their action they add words, gestures, substances to increase the chance of success. People recognise that these words, gestures and other ingredients do not guarantee success – they do not even have a direct physical effect – but 'one never knows'. To explain such magical behaviour we usually refer to psychological concepts and say that it gives us more self-confidence or that it brings relief. Malinowski (1948: 79):

> «Man, engaged in a series of practical activities, comes to a gap; the hunter is disappointed by his quarry, the sailor misses propitious winds, the canoe builder has to deal with some material of which he is never certain that it will stand the strain, or the healthy person suddenly feels his strength failing. What does man do naturally under such conditions, setting aside all magic, belief and ritual? Forsaken by his knowledge, baffled by his past experience and by his technical skill, he realises his impotence. Yet his de-

> sire grips him only the more strongly; his anxiety, his fears and hopes, induce a tension in his organism which drives him to some sort of activity.»

Malinowski's quotation is defensive. He attempts to convince the reader that not only 'savage' people practise magic but 'civilised' people do so as well. In that sense, magic is 'normal', though it remains a slightly irrational reaction, which accompanies scientifically rational behaviour? Malinowski's contribution is that magic is no more something belonging to 'the other'. 'We' in addition, the educated, brought up with the blessings of science, practise magic. However, magic remains a way of thinking which is radically different – even the opposite – of science. It is human to think and act magically, but, writes Malinowski, it does not work.

Magic, therefore, should have no place in biomedicine. It is incompatible with scientific reasoning. The history of biomedicine is one of casting out magic. Medical research, such as randomised and controlled trials, is an attempt to separate specific effects from placebo effects, to distinguish between science and magic.

In biomedical popular language, magic often means 'wrong'. Magic should therefore be eliminated from medicine. In an interview, one of the most prominent Dutch cardiologists remarked: «One third of what happens daily in medicine, is useless. It is magic» (Brandt 1997). Here, magic is still regarded as 'what does not work'. I want to reconsider this negative definition of magic. Magic as «the use of symbols to control forces in nature» (Stevens 1996: 721) is not out of place in biomedicine. It may seem in conflict with biomedical theory, but it is inherent to biomedical practice. Magic, in Malinowski's (1948: 90) felicitous words, is the ritualisation of optimism, the enhancement of faith in the victory of hope over fear: «confidence over doubt, steadfastness over vacillation, optimism over pessimism.» Biomedicine may continue to cast out magic, but it will always remain magical and derive part of its therapeutic success from its magic. Let us now turn to the other – related – dichotomy, between science and religion.

Science and religion

Geertz' (1966) by now classic definition of religion («a system of symbols which acts to establish powerful, pervasive, and long-lasting moods and motivations in men by formulating conceptions of a general order of existence and clothing these conceptions with such an aura of factuality that the moods and motivations seem uniquely realistic») has the advantage that God is not necessarily included in the definition. Religion is a belief in ideas, which are regarded as ultimately true. Paul Tillich (1965) calls religion "ultimate concern". Religion provides believers with sense and security. Geertz' view of religion can be applied to supernatural beings and forces, but also to ideas and explanations which belong to 'science'. The etymology may be wrong, but 'religion' is often derived from the Latin verb *ligare* (to bind). *Religare* could then be translated as to 'bind again', to bring together in second instance. In religion, one could say, a fragmented world, with diverse experiences, is united to form one ordered completely; they are systematised. Things are brought into agreement with one another. The taming of diversity and contradiction into one cognitive system takes place in 'true' religions but also in scientific thinking, including biomedical science.

Without losing sight of a number of prominent differences between 'religion' and 'science' in the conventional meanings of the terms, it is helpful to stress here what they have in common: for those to whom science provides ultimate explanations, it is a religion. Critics may argue that science can never produce ultimate explanations and call this erroneous thinking ('scientism'), but in everyday experience, science does have this status of ultimate truth. To many, only what has been scientifically proven can be trusted as real, all the rest may well be illusion, dreaming or fantasy. Science provides the type of knowledge from which they derive hope, comfort and security.

Calling doctors the new 'priests' is, therefore, more than a metaphor. Doctors have access to knowledge concerning the most relevant physical reality, the human body, and are able to formulate rules for correct and just living on the basis of knowledge. In my country, as in many others I suppose, good health is regarded as the highest value in life. Doctors are the most qualified mediums to point out the 'right way' for those who want to attain that ideal. Anthropologists and philosophers have done their best to delineate and distinguish science, magic and religion. My purpose is to show their overlap.

Magic and ritual in medical settings

Magic has not been pushed back out of our world, as Thomas (1973) argues. Magic and ritual still occur within biomedicine, ranging from the simplest action by a nurse to the most advanced medical technique. Let me give a few examples.

The nurse who fluffs up a patient's pillow does more than make the physical condition of the pillow more comfortable for the patient. The effect of this technical act is multiplied thanks to the fact that it has a wider meaning than its technical one. There is a lot of 'psychology' in this simple action; it shows the nurse's concern and fills the patients with good feelings.

Felker (1983) describes the events taking place in an American operation room as a secular ritual in which not only the premises of biomedicine are confirmed, but also the norms and values of American society at large. A ritual creates order and trust where disorder and insecurity threaten to enter. The ritual reassures the participant that what has been produced by human beings is as certain as physical reality.

The surgeon, together with his/her assistants, plays a reassuring role. She compares the actions in the operation room with Turner's (1974) definition of ritual. Participation in the surgical ritual produces what it expresses. In surgery, someone's body is repaired and more 'repairs' or 'operations' take place; statements about what is real and how we should live are reconfirmed. Felker points at four aspects of this ideology, which is recreated in the operation room. The first is the positive appreciation of entrepreneurship, decisive intervention. Insecurity is defeated by forceful action and not taking action is disapproved of. Surgical work is the epitome of decisive action. The second is the belief in science, which has solutions for any problem that may occur in one's life. The 'miracles' performed by surgeons are the most spectacular examples of science's potency. The third is the view of the body as a machine composed of different parts. The repairs carried out by surgeons prove that this view is correct. The last aspect is the belief in the omnipotence of the medical Doctor. Felker's argument reveals the social, cultural and ideological 'side effects of surgery'. The implication is that the surgeon's efficacy is greatly enhanced by the fact that his actions *make sense* to his patients, that he conjures up trust in what he is doing. In other words, the symbolic quality of his action, *its magic*, works in ways, which fall outside the scope of the biomedical paradigm.

A famous example of the efficacy of symbols in surgery are Moerman's (1979, 1983) articles on the 'by-pass' operation. Moerman argues that the richness of symbolism in the heart operation contributes enormously to the success of the intervention, while that success can often not be proved in scientific terms. Nearly all patients in his study reported to be better after the operation, although in 80 % of them the passing of the blood through the vessels had not improved. Moerman explains this by symbolism. The operation is a religious experience to the patient:

> «By-pass surgery is from a patient's point of view a cosmic drama, following a most potent metaphorical path. The patient is rendered unconscious. His heart, source of life, is stopped! He is by many reasonable definitions dead. The surgeon restructures his heart, and the patient is reborn, reincarnated.» (Moerman 1983: 161)

A last, perhaps slightly anti-climactic example of magic in medicine is the doctor's prescription at the end of a consultation. By taking his pad and starting to write a prescription, the Doctor emits a tactful but definitive sign that the consultation is over. It forestalls further discussion and constitutes some kind of 'silent communication'. The positive appreciation of the prescription does not only conceal the fact that hardly any communication has taken place and that uncertainty still exits, it also removes the patient's disappointment about the shortness of the encounter. For the Doctor, it is the most effective way of dealing with the persistent problem of shortage of time and the 'overload' of patients. Writing a prescription can best be described as a closing ritual which is intended – and often succeeds – to send the patient away with hope and positive feelings towards his medical problem, himself and the Doctor (Pellegrino 1976). Moreover, it provides the patient with an official legitimisation towards his environment that he is really sick.

All these examples show that 'forces of nature' are controlled by actions, which do not make sense if we were to keep strictly to the canons of medical science. The nurse's act is magical *in* its technical quality. In the same vein, the physician writing a prescription shows the patient a token of his concern (Pellegrino 1976), and the bypass operation is at the same time a religious miracle (Moerman 1979).

Biomedicine is characterised as rational/technical. It would, however, be a mistake to conclude that it does not leave room for symbols and magic (with the accompanying emotions). As we have seen, symbols, magic and emotion are found *in* the rationalist-technical approach. Machines and advanced medical techniques conjure up faith, hope and trust, in-patients *and* in physicians.

The Dutch historian Gijswijt-Hofstra (1997: 5) claims that the modern world of today is far from 'disenchanted', as Weber and his contemporaries predicted nearly a century ago, «least of all in the domain of health, disease and curing» (p. 11). To prove her claim she describes the continued existence of magic in phenomena such as folk medicine and prayer healing. She may be right, but it is my purpose in this paper to focus on the place of magic at the heart of scientific medicine and not on magic as a quality of relatively marginal medical practices.

Recovering

A common characterisation (and critique) of biomedicine is that it is atomistic, reductionist and neglects the whole person. We should, however, take into account that atomism and reductionism exists and works only by the grace of an underlying concept of wholeness and unity. The biomedical focus on specific details of the human body bears a striking resemblance with magic and fetishist practices which, following the metonymy principle of *pars pro toto,* affecting the whole person through the touch of a minuscule part of that person. Both are subject to what Frazer (1960) has called the laws of 'contagious magic'. The concept refers to the belief that things, which are in contact with one another, or have been in contact, influence one another. A lock of hair from a lover brings the lover closer. Gordon brought this view forward (n.d.: 6-7):

> «[T]here is an identity between part and whole: the organ is the person. This brings to mind the abundant practices of sympathetic magic ... which take a piece of the person – a lock of hair, a piece of clothing – for the total person himself, and work on this piece to affect the whole. Perhaps we are seeing some of the same processes here in medicine as organs or body parts symbolically stand for the whole person in the eyes and the experience of medical practitioners...»

The term 'recovery' captures this movement from part to whole, from fragment to completeness. Getting better is the result of restoring the whole. Medical intervention, which may appear to be concerned only with one organ, one tiny part of the sick person, is in fact an act of restoring the entire system. Several authors have tried to 'demonstrate' this return to wholeness in medicine through ethnographic description or theoretical argument. Lévi-Strauss' analysis of a Cuna (Indian) incantation to facilitate difficult childbirth is a case in point. The shaman's song constitutes a psychological manipulation of the sick organ. The song, according to Lévi-Strauss, presents the woman in labour with a mythical world in which she believes and to which she belongs. The song is as it were an invitation to take again her place in that world where everything is meaningful to her. What happens during the healing session is that she reintegrates within a whole, which provides her with a sense of belonging. The context conjured up in the song 'infects' her body, she recovers, she recaptures her grounds. Interestingly, the ethnographic example of the Cuna shaman's incantation has been criticised for various reasons, but Lévi-Strauss' reasoning to explain the efficacy of symbols is still widely accepted.

Another anthropologist who took an interest in symbolic healing and tried to explain it is Dow (1986). Dow describes sickness as a fragmentation of emotions and experiences. This fragmentation may take place at various levels of human existence, in a person's natural or social environment, in his self-system, in his body, at a conscious level and finally in physiological processes, which are not subject to individual consciousness.

These various levels are linked to one another and are mutually 'contagious'. Their connection can best be regarded as a metonymy relationship. They border on each other. As a result, a disturbance at one level will spread to another. Thus a breakdown in someone's social life may lead to disruptions in this person's bodily functions, etcetera. The reverse may also happen. Restoration of order at one level can result in recovery at other levels. It suggests that a medical intervention may thus help to overcome a marital crisis and psychotherapy may contribute to the recovery of a somatic disease.

Symbolic healers make use of the connectedness of these different levels. As in the example of the Cuna shaman, they start from a mythic world, a system of ideas, which produces meaning and cohesiveness. Through language and ritual they manipulate the symbols in the mythic world to restore the patient's sense of order. Feelings of coherence must replace experiences of chaos and fragmentation. Powerful symbols, ritual emotion and the healer's charisma determine the outcome of the treatment. If the patient's sense of coherence is restored, this will be spread to other levels of human experience. Optimism and confidence return and take possession of the body. The patient recovers. The prefix 're' proves indispensable in finding words for the process which takes place in and around healing: repairing, re-capturing, recovery, re-storing, recuperation, re-generation, reformation and religion (*re-ligare*). Rituals and sacraments have a repetitive character. Repetition and remembering create recognition and make reintegration possible. They 'frame' experiences, put them in a certain place where they reconquer their meaning. Repetition of stories, prayers, song lines instil that idea upon the participants. Rituals often have a mnemonic effect, like tying a knot in a handkerchief. Rituals focus attention by framing and enlivening the relevant past (Douglas 1966: 79).

Liturgy and sacraments

I am not using the terms 'liturgy' and 'sacrament' simply as other words for 'ritual', just for a change, as seems to be the case in Atkinson's (1995: 148-51) use of 'liturgy'. The terms signal that I indeed descry a religious mood in the way medical services are offered and received.

The term 'liturgy' is derived from the Greek word *leitourgia* (*laos* = people; *ergon* = work), which referred to the work citizens were obliged to carry out for the state. Later on it assumed the meaning of rituals conducted in churches according to prescribed forms. Liturgy in present-day language usually refers to religious practices in Christian services, in particular the Eucharist, the ritualised remembrance of Christ's last meal with his disciples, before he was put to death. 'Liturgy' is used in contrast to private devotion.

'Sacrament' originated from the Latin *sacramentum*, which has three meanings: 1. Deposit or bail, a sum of money which contestants in a court case deposited and which was given to the winner of the case; 2. Oath taken by a Roman soldier that he would not abandon his general; 3. Early Christians gave 'sacrament', its present meaning of a visible sign expressing some mystery of their faith. The Roman Catholic Church recognises seven sacraments which, according to Christian belief, have all been instituted by Christ. Most Protestant Churches accept only two sacraments: baptism and the Eucharist.

In the Catholic view, a sacrament is, in Augustine's words, «the visible form of invisible grace.» Through the sacraments God's grace is channelled to the recipient, the believer who takes part in a sacrament. In anthropological terms, sacraments could be regarded as indexical signs of a reality, which cannot be observed or experienced directly. They are concretisations of an ungraspable world. For the faithful they make visible what they believe exists but cannot be seen in their real form. By participating in sacramental rites, people feel comforted and confirmed in their faith. They receive what Christians call 'grace' and Moslems '*baraka*': strength, blessing and spiritual power.

In order to clarify the meaning of 'grace', theologians sometimes use medical metaphors. What medicine is for the sick body, is grace for the soul. In popular German devotion, from the 16th century onwards, Christ has been portrayed as a pharmacist distributing medicines for the soul. Hein has identified 133 representations of Christ as a pharmacist. Most are oil paintings while others copper plates, drawings or stained-glass windows. Thirty of these have been brought together in a publication (Hein 1992).

Most portraits are elaborate allegories. The objects of the pharmacy take on a spiritual meaning. The medicines become Christian virtues, which are needed to achieve spiritual 'health'. One can obtain these 'medicines' from the pharmacist Christ. Books and sheets on the counter show us prescriptions, not for the body but for the soul. The scale, a conventional pharmacy instrument, normally used to measure the correct dosage of medicine, is here a symbol referring to the Final Judgement where each individual will be weighed and judged. The outcome will be either salvation or eternal damnation.

Pfeiffer (1992) provides an extensive theological and bibliographic commentary on each detail of one such painting, giving references to relevant biblical and devotional texts, as well as on explanations of the various Christian symbols depicted. In biblical texts, God is frequently portrayed as a healer («I am your Lord, your Healer», Exodus 15: 26). The healing metaphor is particularly strong in the New Testament, which contains numerous descriptions of Christ healing sick and handicapped people. At the same time, however, it is made clear that spiritual health is infinitely more precious than physical health. Christ's ability to cure the body is an index of his spiritual healing power. In the Gospel of Matthew, Jesus forgives a lame man for his sins. Some onlookers accuse him of blasphemy. Matthew continues:

> «But Jesus, knowing their thoughts, said, 'Why do you think evil in your hearts'? For what is easier, to say, 'Your sins are forgiven,' or to say, 'Rise and walk'? But that you may know that the Son of Man has authority on earth to forgive sins – he then said to the paralytic – 'Rise, take up your bed and go home.' And he rose and went home.» (Matthew 9:4-7)

Medical metaphors for spiritual gifts also abound in the writings of the Church Fathers and the theologians of the first centuries, the Middle Ages and the time of the Reformation. Pfeiffer (1992) quotes the following prayer of St Thomas of Aquinas: «I come to Thee, as a sick man to the physician of life, as a dirty man to the bath of mercy, as a blind man to the eternal light... Cure my sickness, wash away my stains, and enlighten my blindness». Luther calls the Holy Communion *eine Arznei der Kranken* (a medicine for the sick) (2).

Metaphors work in two directions. If medical images help to grasp religious emotions, religious experiences may also clarify medical events. The medical techniques and interventions, which I previously presented, could indeed be viewed as religious phenomena.

What religion and medicine have in common is their opposition to death. Malinowski regards death as the source of religion:

> «Man has to live his life in the shadow of death, and he who clings to life and enjoys its fullness must dread the menace of its end. And he who is faced by death turns to the promise of life. Death and its denial – Immortality – have always formed, as they form today, the most poignant theme of man's forebodings.» (Malinowski, 1948: 47)

> «Religion saves man from a surrender to death and destruction, and in doing this it merely makes use of the observations of dreams, shadows and visions. The real nucleus of animism lies in the deepest emotional fact of human nature, the desire for life.» (Malinowski, 1948: 51)

Religion is here presented as the ultimate expression of hope against the reality of death. In his monumental *Das Prinzip Hoffnung* [The principle of hope], the German philosopher Ernst Bloch designs a philosophy and anthropology in which hope, looking optimistically to the future, is the basic movement of human existence. Not only religion, but also fairytales, popular fiction, theatre, dance, film, travelling, medicine, technology, painting, poetry, opera, and above all music are presented as evidence of the human orientation towards a hopeful future, a better world. The human person is a Utopian being, a dreamer and believer in the possibility of a good life.

Bloch, who never quotes Malinowski, finds himself in the company of the anthropologist:

> «The jaws of death grind everything and the maw of corruption devours every teleology, …But all the more powerful is the necessity to set *wishful evidence* against this so little illuminating certainty, against a mere factual truth in the world unmediated with man.» (Bloch, 1986: 1107)

Bloch elaborates his view by tracing the death-denying trends in several world religions. In the Jewish and Christian Bible we see how an initial acceptance of death is replaced by a belief in an eventual resurrection. According to Bloch, this development cannot be merely explained as a desire for endless life but should be seen as the outcome of a «thirst for justice» (p. 1126). «The world is full of slaughtered goodness and of successful criminals enjoying a long and peaceful old age», Bloch noted a few pages earlier (p. 1106). Religion, thus, not only saves us from surrender to death, as Malinowski wrote, but it also prevents us from falling into chaos, as Geertz – and many others – remarked. Religion's answer to the threat of metaphysical and ethical chaos (bafflement and suffering) is:

> «[T] he formulation, by means of symbols, of an image of such a genuine order of the world which will account for, and even celebrate, the perceived ambiguities, puzzles, and paradoxes in human experience. The effort is not to deny the undeniable – that there are unexplained events, that life hurts, or that rain falls upon the just – but to deny that there are inexplicable events, that life is unendurable, and that justice is a mirage.» (Geertz, 1973: 108)

Questions about metaphysical sense and moral justice, as we will see in a moment, also befall the seriously sick patient in hospital.

For Bloch, the principle of hope lives on in a world that has done away with the metaphysical beliefs of the conventional religions, which deny the reality of death. His own Utopia is not situated in a life after death or a life in defiance of death, but in a socialist society (which to most of today's readers is almost as difficult to believe in as in life after death).

Christian theologians have been deeply influenced by Bloch's philosophy and have tried to develop a theology of hope, which can be reconciled with Bloch's radical secularisation. Moltmann (1964), following Bloch's concept of hope as the ground of human existence, sketches the Christian faith as rooted in and fed by hope. Simple promises of a death-less future are, however, difficult to find in Moltmann's complex theological treatise. Both Bloch and Moltmann reject a passive acceptance of a status quo and argue that life is not worth living without the prospect of an alternative, without hope, whatever that alternative is, it seems.

For the patient who is critically ill, the alternative is clear and concrete, however. His hope is to get better, to recover his health, his life. In this case, hope for life after death becomes hope for life after the threat of death. It is also hope for justice as described by Geertz. To die before one's time raises doubts about the moral order and meaning of life. Being seriously sick and facing a possible death is therefore a religious experience. The nurse and Doctor fighting for the patient's life become participants in a religious drama. Their actions – technical interventions and caring gestures, as well as the medical substances – assume religious significance. They feed the patient's hope for recovery, his/her desire for life. They could indeed be called 'sacraments', as I suggested earlier, not merely in a metaphoric sense. They *are* active ingredients fulfilling the patient's hope for a continuation of life. Biblical texts, which are quoted in Christian sacraments, strikingly suit the condition and wishful dreams of the patient: «Rise, take up your bed and go home» (Luke 5: 24). Or: «I am the resurrection and the life; he who believes in me, though he die, yet shall he live» (John 11: 25). Or: «If anyone eats from this bread, he will live for ever» (John 6: 51). People today, including patients in hospitals, may not believe the miracles reported in the biblical books; they do, however, believe in the miracles of medicine.

Hope for recovery, optimism against all unfavourable odds by critically ill patients, takes a central place in research among cancer patients in a Dutch hospital (The, 1999). The author describes the healing power of hope but puts even more emphasis on hope's deceptiveness. In their 'desperate optimism' patients take 'bad news' for 'good news' and doctors contribute to that misunderstanding by their euphemistic and veiled way of speaking. What is remarkable about The's study is that although when she set out to study euthanasia in a hospital setting, she expected to find a wish to die among terminally sick people, what she actually found was a strong desire to live. Words, gestures, interventions and medicines were taken as signs of a hopeful future. Nurses became angels with reassuring messages, doctors appeared as priests and thaumaturges on whom they fixed their faith and hope for ‘resurrection’.

Concluding remarks

Anthropologists have outdone each other in depicting biomedicine as a cultural no-man’s land, an inhospitable place where patients are deprived of their most cherished values and subjected to a dehumanising regime of objectification. My aim is to defend the view that *biomedicine represents the basic values of its culture*. It is a space where doctors, nurses and patients find their deepest convictions and values demonstrated and confirmed. Hospitals and other medical institutions thus become secular churches where people perform acts and speak words, which express and recreate their belief in the canons of ultimate truth (i.e. science and biomedicine). «Medicine, or faith in medicine, is a creed» (Lupton, 1994: 1).

Scientific, i.e. biomedical concepts and images fill our mind when we think about our well being, our past, our future and ourselves; they form the stuff of our dreams. Biomedicine is a science we believe in. It produces its own magic. This thorough embeddedness in culture provides a more satisfactory explanation for the efficacy of biomedical practice than a purely scientific one. Symbolic healing merges with biomedical treatment and reinforces its effect.

Divorced from its cultural-symbolic character, biomedical efficacy becomes unintelligible. As in symbolic healing (Dow, 1986), medical intervention at one level spreads to other levels of a person’s living system. Order restored in one place ‘infects’ other places; pessimism gives way to confidence and takes possession of all levels of being. The patient recovers. The moral, psychological and religious meaning of biomedicine must not be sought *next to* knowledge and technology; in the manner medical care is given to patients. They are *in* the medical activities and attribute themselves. They are the realisation of science, magic and religion. Magic and religion flourish in the heart of biomedicine.

This observation should not be taken in a derogatory sense. It refers to the fact that medicine is thought and practised by people, meaning-producing beings. Doctors, nurses, patients and their relatives are hopeful and anxious, full of trust and full of doubt, pessimistic and optimistic. These emotions and expectations contribute to and are expressed in medical practices. Our visual imagination of emotion has conservatively stuck to conventional symbols such as sweet-scented flowers, cleft hearts, caring hands, colourful sunsets and smiling children. The cold and sterile machinery of intensive care units with their monitors, tubes and sensors and the forbidding appearance of the specialist with his gruff voice also conjure up emotions. They too have sacramental effects. Therapeutic efficacy is co-produced by ideas and emotions, words and gestures, which may fall outside the scope of medical science and are interpreted in anthropology. The acknowledgement of this 'magic' opens a rich potential for future medical and anthropological research.

Closing prayer

In a fascinating study, the Dutch psychiatrist Van der Hart (1978) pleads for the use of rituals in psychotherapy. He derives his examples from anthropological research in various cultures where rituals are reported to have a wholesome effect on those taking part in them. He refers to rituals carried out in periods of conflict or distress, after someone's death or during life transitions, for example from childhood to adolescence. His examples are 'real', explicit rituals. The participants were fully aware of their behaviour as being ritual. In this paper I have drawn attention to something else. I have pointed at rational-technical medical activities, which are not intended as rituals but which do have a symbolic character and a subsequent ritual 'side-effect'.

I have tried to argue that the ritual character of medical treatment constitutes a substantial – but usually ignored, even rejected – part of its efficacy. I consider this good news, which, unfortunately, is often badly received. Medical professionals usually react with irritation at the idea that their therapeutic work has a symbolic effect, when it is called 'magic' or is compared with religious and ritual behaviour. They tend to take this as anthropological arrogance ridiculing and belittling their medical knowledge and practice. Another common reaction is that what I call 'magic' or 'ritual' is "just psychology". I agree: just psychology. Psychology, after all, is a new name for what Malinowski called 'magic' among the Trobrianders. Mary Douglas, in her 'magical' essay on concepts of pollution, also points at the overlap of magic and psychology:

> «Not the absurd Ali Baba, but the magisterial figure of Freud is the model for appreciating the ... ritualist. The ritual is creative indeed. More wonderful

> than the exotic caves and palaces of fairy tales, the magic of… ritual creates harmonious worlds with ranked and ordered populations playing there appointed parts. So far from being meaningless, it is… magic which gives meaning to existence.» (Douglas 1966: 89)

Three times I replaced a term with three dots in Douglas' quotation; three times the same adjective: 'primitive'. In her essay, magic and ritual seem very much tied up with the culture of what was carelessly called 'primitive people'. My point throughout this paper has been, however, that magic and ritual are indispensable elements of any culture, 'high tech' as well as 'primitive'. However, we must not quibble over terms. Whether we call it magic, ritual, sacrament, placebo effect or psychology, the point is that we must recognise and take advantage of the added value which medical work, because of its symbolic significance, accrues in the bodies and minds of sick people.

Notes

(1) This essay builds upon an earlier paper presented at the First European Conference "Medical Anthropology at Home", Zeist, The Netherlands, 12-18 April 1998.

(2) For a more elaborate discussion of medical metaphors in religious expression, see Van der Geest, 19-94.

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 259-288

Medicine, magic and religion in a hospital ward.

An anthropologist as patient (1)

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To Marta, Eduard and Pol

1. Orpheus

In the early summer of 1991, my wife, my children and I were involved in a horrific accident in the Spanish region of Alcarria. The motor home we were travelling in burst into flames. The children were unhurt but my wife suffered serious burns from which she was able to recover only after a long period of treatment and rehabilitation. On the same day we were admitted to different sections of the same burns unit. My wife was put in the Intensive Care Unit (ICU) while I was admitted to the general ward. We were separated by just over fifty metres. She remained in a pharmacological coma for six weeks and for two or three more weeks she was on that fine dividing line between life and death. She then spent five months in intensive care, a further six months in rehabilitation and for two more years she made daily visits to a rehabilitation centre. Today she leads an extremely active life. Her experience became the subject of an autobiographical text (Allué 1996).

My own injuries were more localised and needed just a couple of weeks in hospital and a month of superficial treatment outside. In the hospital ward, while trying to cope with my anxiety as best as I could, I kept a diary. Ever since the accident I had felt a compulsive urge to understand what had happened to us. While I was being taken to hospital and felt the tremendous thirst that burns cause, my brain began processing data at top speed in an attempt to explain why my vehicle had set on fire. In the hospital, some fifty metres from my wife, my relatives and friends built up a wall of silence. «In here he isn't a Doctor» they told the doctors, «he's just a patient». Information about my wife was selected carefully. Nothing was left to chance. Visits to my wife were banned. Information was scarce. During the first couple of days my senses were dulled by tranquillisers, I was covered in bandages and I did not really know what was going on. When I had regained a certain degree of serenity I asked for some paper and a fountain pen. My writing must have followed a sort of confused process in which my two professions of anthropologist and psychiatrist fought to rebuild my identity in the anonymity of a hospital ward. I could not accept the passive role of the patient. Nor was I yet fully aware of the seriousness of my wife's condition – despite the alarming signs. In my diary a confused hotchpotch of field observations, clinical comment and personal emotions emerged. It was as if in all the confusion my various identities were battling with each other to fill the uncertainty. I was not able to take a detached view of the institution and, despite my normal curiosity, I never managed to become a systematic and aware observer. Out of these notes I began to write a personal diary.

Against the early ominous predictions of the plastic surgeons, the question of my discharge came up after a fortnight. As time went by I had guessed more and more of the truth and this awareness of the situation was, I think, a deciding factor in my leaving the hospital. I have since seen many patients with only half the injuries I suffered remain in the ward for weeks. My status as a Doctor clinched my discharge.

I had entered hospital with just the clothes I had on. All our belongings had been burnt. I asked my mother for a wallet and a photocopy of my identity card that, as luck had it, she kept. I could not leave the hospital without documentation, without an identity. I left without seeing my wife. I could not. I was not to know then that it would be another three interminable weeks before I saw her again. I went home to pick up my things. From the window of the train I could see the hospital drawing away. I shuddered, fearing the worst. I now knew the situation. I resolved my domestic situation before taking the train. When the train got into the station I stayed alone in the deserted and silent summer in Madrid. I did not have the courage to visit her. Outside the hospital, while my wounds slowly healed, nausea was eating away inside me. After the first weekend, my friends took the shuttle to Madrid to keep me company. For more than two months *Chamartín* station became the place for swapping over shifts. Days passed ever so slowly and the news was always bad. At first I thought that my diary would help me to overcome my solitude and nausea. The pact of silence at the hospital only broke for a few short minutes every day – at one o'clock in the afternoon. The minimal information I was given was always the same. The remaining twenty-three hours and fifty minutes were a constant torture. My friends organised a strict military regime for me. My role as both Doctor and patient faded rapidly and the arrogance of the former was replaced by an unrestrained feeling of impotence, of horror at my uselessness, weakness and inability to react. I dreamt of sleeping for two whole months and made crazy plans and projects. I drew up several funeral protocols during the interminably long nights but I refused to accept that she could die. Those around me were instructed to leave no room for hope so that the final blow would be less. My instructions to myself were to go all the way without losing hope. In the worst moments I was the only one who believed that this was possible. I lived miserably. I was weak, fragile, gripped by my selfishness and the few shreds of arrogance I had left. I forced myself to bring a computer and every day I sat down to write. Nevertheless, I could not. I just switched it on and looked at the first paragraph. Nothing. I did not think then about narrating or reconstructing the process. I took on the role of the defenceless layman who tries to survive in the face of the death of a loved one and lets he go. However, I did not dare descend into hell itself.

In the middle of August 1991 the nursing staff urged me to enter the ICU to see my wife. I resisted because I could not allow myself to watch her die. I wanted to remember her as she was when she was alive, not wrapped up in a dirty shroud of bandages. The voices became more persistent. A number of signs seemed more positive. During the week of the August public holiday in honour of our Lady when Madrid, deserted by its inhabitants, becomes a ghost town, rumours of her survival grew louder. Shielded by my close friends, I finally went in to see her. She heard my voice and started to cry.

The ICU then became my home. I do not think I was ever a good companion as I was unable to fully assume the role that was dominated then by my status as a Doctor and my obsession with therapy. I struggled constantly between my roles as husband, friend, psychiatrist and Doctor, obsessed by the need to be useful after so many weeks of feeling useless. I did not understand that my idea of usefulness was not the same as hers. I failed as a companion, father, husband and therapist. I was unable to resolve the contradictions caused by my numerous identities. With a steely determination I wanted to administer a case that seemed to me to be the case of my life, without realising that it was not my life on the line but that of my wife. I did not realise that the reasons for my failure were that I had not recognised the drama, or I was blinded by it, and that I had not noticed that she had taken on a strong awareness of her own independence, a strong ability to control the process herself. I wanted to be like Orpheus returning to the underworld to save Euridice. I forgot that Orpheus failed.

Two years passed before I could go back to the subject. Marta was finishing the second draft of her book but she did not know how to fill the gap left by her pharmacological coma. This was necessary for the logical sequence of her narrative. She suggested that I act as an informant but warned me that instead of an anthropological text she just wanted a written account. She used only a part of what I gave her because she quickly realised that my professional identities and my distress slanted my view at the time. She decided that this part of the story should be in a different font so that one part would be a summary of her case history and the other a neutral account in the third person that ended with an evocation of the myth of Orpheus (Allué, 1996: 21-24).

The draft I prepared helped me to begin to understand what I had not wanted to understand and at the same time to discover a new meaning for my experience. I used it partly to make a kind of self-analysis and partly to approach a world that has not been widely studied by anthropologists and clear up a few contradictory aspects of hospital care. I used the first draft, a year later, for an interdisciplinary meeting (Comelles, 1995). Now, some years later, I can reconstruct my personal moral career and take some distance from the facts.

2. *Hell*

Twenty years ago patients with burns on more than 50% of their body usually died. Today patients with severe burns on more than 80% of their body *pull through*. Assuring their survival is a complex clinical problem that can only be tackled by the burn units. They carry out advanced multidisciplinary research, perform experiments in therapy and train plastic surgeons, intensive care personnel and nursing staff. Ideally, they have an intensive care unit (ICU), a hospital ward and operating theatres. They are “closed” wards.

The unit where most of the observations were made is on an asymmetrical T-shaped floor. A door divides the main wing into an intensive care unit for severe burns *on the inside* and a general ward *on the outside*. The first section occupied 40% of the space and consisted of a dozen partitioned beds, nurses’ room, doctors’ room and a large treatment room with a

Hoffman tank for baths. The general ward consisted of a dozen rooms with two or three rooms for minor injuries or for patients *who had pulled through*. It also had a treatment room with another Hoffman tank (Allué 1996: 56-64), offices and other rooms. In the wing perpendicular to the main corridor were the operating theatres. Described in this way, a burns unit is quite a complete little hospital. Staff included plastic surgeons, intensive care staff, rehabilitation staff, nurses, physiotherapists, occupational therapists, orthopaedists, ancillary staff, epidemiologists and microbiologists, and occasionally a psychiatrist and a priest.

The treatment protocol for treating major and minor burns has changed little, even since the latest technological boom. It consists of surgically cleaning the wounds, regular care and skin grafts. On admission patients are bathed, their condition is assessed and, according to the depth and extent of their burns, they are intubated, sedated with opiates, given assisted breathing equipment and monitored. The necrotic tissue is then removed from the burnt areas and the grafts that will cover the areas where it is thought that the skin will not re-grow are planned. Topical treatments and normal everyday medication are formalised, as well as general large-scale therapy every two or three days that is independent of surgical intervention. A patient may receive surgical intervention with a general anaesthetic a dozen times in the minimum two or three months of a treatment that can continue for years.

The major aim of the treatment is to put patients in a position to generate new skin by preventing infections from the environment and somatic complications. The main causes of life risk in burn patients are damage to lungs due to fumes, renal complications caused by the metabolites of the burnt skin and the side effects of the treatments (2).The surgical protocol is designed to cover the maximum of burns quickly (3). This depends on the availability of skin to draw from since it is still impossible to produce artificial skin. Medical care keeps patients alive until their wounds heal: «*what cures the burns victim is time, just time*», said one plastic surgeon. This axiom has not changed.

3. *Living dead*

When a badly burnt patient is admitted, the plastic surgeons are faced with a dilemma. They know that recovery will be a long process. They know that they have excellent resources but they also know their limitations. What they do not know, however, is whether the patient *will pull through or not*, although they might be aware of the probabilities involved. The extent and depth of the wounds, age, sex, physical condition and build can give some idea of the patient's future prospects, but his *resistance* will not be known until the end of the process. The decision about whether to let patients die or to try to keep them alive is based on the experience of the practitioner, his beliefs, social considerations and the pressures from the patient's social network. Doctors and nurses know that their decisions will be called into question for months or years, during which time they will have to share a long moral career. They know that there is a possibility of recovery, except when there are no donor regions or when there are serious somatic, respiratory or renal complications (4).This possibility, however remote, which terminal cancer patients do not enjoy, is important for shaping the culture of the organisation and, together with the overall results of their therapy, justifies the units and their protocols.

However, whenever they have to make an uncertain prognosis the medical profession always expresses it as a *very* or *extremely critical* one. This means that the patient has little chance of pulling through. This contradictory position means accepting that the intensive care therapy can be performed without their requesting the opinion of a patient whom is conscious on arrival. Analgesia is induced by pharmacological coma via opiates and psychoactive drugs. This therapy needs assisted ventilation, and later tracheotomy. This protocol is followed to ensure a patient's survival but at the same time it removes his social condition. It kills a patient socially, converting him into a dead being who is unrecognisable through the windows, through which his social network can see him twice a day.

In the burns service the patient is no longer a social *being*. It is not simply a question of reification of patients by the medical world. In this arena patients become non-people irrespective of their will or decision-making abilities and they are prevented from interacting with their environment because their only outputs are their biological parameters obtained from monitoring or from analytical or microbiological protocols. This attitude to therapy and diagnosis is rationalised by saying *«it is better that he doesn't know too much about it, for his own good»*. However, this view collapses under its own weight when one sees how analgesia is haggled over in the series of interventions that follow treatment.

We have gone beyond what used to be understood by reification of the body in classical clinical exploration. This examination was a non-verbal interactive language involving the Doctor, the patient and the members of the patient's social network who waited around expectantly. In the situation we are trying to describe, this interactive language is also abolished as the body is only explored through monitors that provide information, either written or on screen, about what is happening. The patient is not a living being: he is an on-screen *representation.* Alone in the ICU the patient is almost non-human. «*Marta is a thing*», someone said. In ICU Marta, like Vicente, «*is a pipe*». A *pipe* is a patient connected to tubes who «*is waiting to be taken to "El Corte Inglés"*» i.e. to surgery (5), «*one of these days. Who's that?*» Asks the visitor. «*Oh, that pipe… he's dead*», replies the nurse, «*we're keeping him here with the pipes 'till they come to take him away*». A living dead person among the dead beings, sharing the monotonous rhythm of the ventilator. Whether the patient recovers or not is irrelevant since what is being administrated are only what remains of the patient's biology: there is no wish to take on the *travail de deuil*. To *allow* the patient to *die* is apparently an exonerative process considering the limits of knowledge, a way of saving face if things go wrong and picking up medals if the patient is saved. It is to practise a kind of indifference that is indispensable for doing a job in which one contemplates horror and suffering on a daily basis, and a way of avoiding or renouncing the function of social support and sociability that existed at the birth of hospitals. However, horror cannot be sidestepped and by organising the unit along hierarchical lines, its administration is reduced. Plastic surgeons pay their visits, do their rounds early and come back from time to time if necessary. Staffs in ICU shut themselves away in the ward and discusses the laboratory data. Nurses and ancillary staff come in and go out to change drips or take samples. The more *pipes* there are, the worse the overall service, the higher the absenteeism, and the more obvious is people's irritability. To cope with all this, artificial practices of ritual sociability are drawn up. Staffs holds celebrations and parties, but outside accomplices are sought for them. Visitors who do not enter are told that they should because although the patient is in a pharmacological coma there is a field of interaction between staff and the patient.

Bringing the patients *inside* removes them from their social network and shuts them away in a secret place, in which not even the most elementary of the vital processes are controlled by the patient. This takes the idea of total institution to the limit. The idea of social death in total institutions reaches its highest degree of perfection here. Inside they try to remove all subjectivity, since clinical decisions are based on the continuous evaluation of a set of objective parameters that limit the role played by clinical intuition. The interaction that used to take place between patients, their social network and professional staff around the development of the illness is being lost, while the discussion and negotiation about whether to continue with a treatment excludes laymen and patients, who are considered incapable of deciding for themselves. Information becomes unidirectional i.e. from the *inside* to the *outside* and is synthetic e.g. «*he's not very well, he's better*», «*he has a sepsis*», and «*he's not breathing too well*». It does not communicate any vicissitudes or the decisions that are constantly being taken and that are reflected by the spectacular thickness of the medical records. There is no room *inside* for the emotional support that guaranteed the traditional doctors their customers and prestige, since the patient is socially dead. Hospital practice, therefore, tries to remove the social and cultural aspects of the patient's body and relegate them symbolically to the *outside* of the hospital. However, it cannot. Sociability grows outside.

To allow the patient to die socially is a therapeutic strategy that clashes with the fact that the patient retains certain ability for perception and oneiric interpretation of the environment. He also retains an ability for non-verbal interaction that begs a number of questions about his sociability, not so much towards the doctors but towards the nurses who spend more time with him and have to make an effort in order to understand his demands (6).

They can feel that he is responding to stimuli, that he can open his eyes amid the pharmacological haze. A rather esoteric theory about this type of communication is constructed, which as such is incorporated by the nurse better in her capacity as a citizen than in her capacity as a nurse. In addition, although the dead being is not attributed with the ability to act socially, members of his social network act as his representatives (7).

4. *Living in hell*

In Spanish hospitals, as a result of a very deep-rooted cultural pattern regarding the responsibility of domestic groups in managing health/illness/care, the close family consciously assumes the role of *representing* the dead being. *Staying* with the patient may involve staying for hours in the corridor, *outside*, irrespective of the rules and timetables, and making deals. Unlike in the United States we do not have a well-established legal framework for regulating the rights of the individual patient or his legal representative. What we have are a series of uses and customs relating to the collective responsibility in matters of illness, and therefore an order of representation that is more collective than individual and based on the common laws for the social management of illness. In the Anglo-Saxon world of informed consent, the patient delegates his legal rights in writing. In our environment, his social networks are his representatives. The dead being is *inside*, but he lives and has his voice *outside*. The *presence* of the patient in the body of his relatives is fundamental to an understanding of the fundamental contradiction between a model of a hospital that is autonomous and socially and culturally independent and a common law reality that is in contradiction with the former. Hospital staff are therefore constantly torn between their professional identity and training and their identity and experiences as citizens in domestic management of illnesses i.e. between their professional (cultural) identity and their cultural identity. Finally, since the American model delegates' legal representation, it provides professionals with a negotiated order inside a legal framework. In Spain they constantly have to negotiate new adjustments because the rule developed is the result of spontaneous and constant dialectics that cannot generate any kind of jurisprudence other than experience itself. Medical training does not attempt to sort out this contradiction between the rational and the emotional since it considers the emotional to be purely irrational, archaic or borne out of ignorance and superstition. Rationally oriented decisions are therefore always justified so as to ensure their supremacy over emotion.

Although the medical model has not solved this problem by incorporating it, it tries to do so with formal, expert practices, using the value that science has acquired in popular knowledge to protect itself. In the first place services are closed. The reason given is the risk of infection but it is mainly to provide a protected area in which to take decisions without being influenced by sentiment, to limit the supply of information to a minimum and to feel under less pressure, since pressure is a form of power. This means that doctors can walk without covering their shoes, smoke in the ICU corridor, work without rubber gloves or rationalise the lack of communication with relatives by saying *«it's better that you don't know too much, in fact it's better that you know as little as possible»*.

Then there are the rules and regulations that attempt to justify segregating areas and concealing medical activity. These rules and regulations are intended to administer the relationship between staff and the *presence* of the patient, represented by his social network. One learns about emotional indifference, the creation of hierarchical distances, how badges are used and how reserved areas are created. All of this is based on a rationalisation that stems from the intrinsic and indisputable goodness behind the decisions that are taken.

By refusing the opportunity to understand how important social and cultural aspects are to the caring process, the medical model displays its most negative side: the lack of technical resources needed to solve this problem of communication and support leaves the door open to conflict, irregularity and dealing. Instead of understanding and learning, however, the staffs answers in a variety of ways, each of which is just as bad as the other. They accuse laymen of being ignorant or coarse. They call them *uncultured.* They apply entirely police-like criteria, thus exacerbating the conflict. They agree to *turn a blind eye* and set up a system of discretionary deals, which is obviously always unfair (in health service jargon a patient is known in such cases as *a recommended one*). However, threats and coercion are also used to create the picture of the good patient, i.e. one who keeps quiet and accepts whatever they give him, as well as that of a bad patient, i.e. one who asks what and why they are doing what they are doing.

The socially dead are still sociable people, however. «*Sometimes, when half awake he looks at us as if he's asking us something. We tell him things and he sometimes wants to reply*». The problems they cause produce contradictory responses. Nurses and ancillary staff encourage relatives to go *inside* to *cheer them up* and *give them the will to live.* They encourage them to break through the barriers of space and secrecy, to help them to *get through it* despite the attitude of medical care that advocates that «*the best thing for them is to sleep*» and «*to be awoken as late as possible*». The nurses sense the therapeutic value of sociability, or at least rationalise it because they know that the relatives who feed the patients and keep them company are less work and do not call so often.

It is this fragile patch-up theory that causes the defences of the professionals to tremble. Sometimes they tremble on a long-term basis – this is the *burnout syndrome*. More often they require the complicity of the patient's social network in the management of care. Their professional ideology has been built around care and, therefore, on shared experiences, so the horror cannot be combated with such efficient resources as those of the doctors. For this reason, female nurses sometimes weep while some male nurses become expert mini-doctors, as a form of escapism, and others turn to violence, torture or sadism.

Doctors are in a better position to cope with the horrors because the rhetoric on which their practice is based is more epistemologically sound. This is because they have rejected care and support in favour of diagnosis and therapy. Their position in the hierarchy allows them to escape and hide, without it being noticed, or be ready at midday with all the necessary information. However, they are besieged, feel criticised and go on the defensive. If we understand strategic professional aloofness as emotional indifference, it is difficult to explain it rationally in a society in which to pay attention to the patient still implies being in continuous contact with him.

Right from the outset the doctors' attitude is to try, not very subtly, to make the patient's relatives share their emotional indifference, to «*accept the harsh reality*», to «*get used to the idea of not seeing him or her ever again*», and wait for the fateful outcome by doing nothing. A positive outcome is never guaranteed. «*I saw her today. When I arrived, she was horrible. She has no skin, she's got terrible scars and she's in a bad way. She's going to die, she's almost certainly going to die*», the very nervous woman Doctor told the visitor who was pestering her, before moving away, still speaking but not looking at him. The word "almost" offers a ray of hope, gains a bit of time, and makes the waiting shorter. Professional defence mechanisms are fragile things. They work more or less well in hospital situations where there is a high turnover of patients that normally stay for between a few days and two or three weeks. In Burns we speak in terms of months, slow progress, occasional crises and how to be patient when everyone – doctors, patients, visitors – has to be patient.

The organisation is unable to resolve these contradictions. Firstly, because of the fundamentalism behind the theoretical positions on which medical discourse is based. Secondly, because of the lack of any self-criticism. Thirdly, because there are no analytical instruments to tackle problems or suggest other organisational frameworks that does not view medical care as a service for the professionals but as a complex reality, that rejects the patient's *social presence*. It is often claimed that these distancing strategies are intended to increase the charisma of the Doctor, using resources designed to increase people's admiration for them so that that they can retain their power. I agree with this view to a certain extent but I would also like to point out that the burns unit also reveals the intrinsic weakness of the position of the Doctor and other staff. This weakness stems from the fact that it is impossible to guarantee that the therapy proposed will be successful. Medical literature of the 19th century shows that doctors knew they knew very little and that at best they could make forecasts with some success. They did not claim to find cures but they knew that they had to keep the support of the social body, the *social presence* of the patient. The hospital Doctor wants to cure the patient but does not know whether he can. Both the doctors and the nursing staff want the social presence to believe that a cure can be found so that they do not have to seek their support, which would distract them from their hypothetical care work (Comelles, 1996, 1998). This turns the commonly held view of the power of the Doctor, the powerlessness of the patient and the desperation of the patient's social network into a more complex situation. Firstly, the doctor's power and the patient's desperation are reflected in their behaviour and, in our case, in the patient's oneiric production.

Secondly, the impotence and desperation of the medical staff emerge as they see the limitations of their ability to make prognoses and to cure. Thirdly, there is the power of the social network, and also its powerlessness as it sees that its opportunities for collaborating in the process are denied.

5. The experience of uncertainty

The critical period has no clear limits. *«If they go beyond forty days they usually recover»*, one nurse told a group of relatives. If the days go by and the patient does not die, hope is not lost. Nevertheless, the way ahead is uncertain, *«he's still poorly»*, *«he's very poorly»*, but nobody knows what makes him *resist*. *«They have a will to live, something within them makes them carry on,* say the nurses. *I don't call people when they're suffering: what's the point? When they die we'll ask their relatives to come»,* said one woman Doctor. Gabriel died alone early one morning. They called some time later. Nothing gets in the way of the logic of the institution even though Gabriel is conscious and he knows that he is going to die as he contemplates his leg that was amputated in a routine operation two weeks earlier.

Dead beings spend their days not knowing whether they will revive or die. Others pass their time in the waiting periods any way they can. Plastic surgeons spend their time between operations, grafts and baths. In the intervening periods they wait, powerless, while the intensive care unit staff attend to the patient, while the body resists and the grafts take, and until time passes. If the operations are delayed it is because the patient would not be able to cope with the surgery or the baths, and the relatives suffer. *«Every morning when I got up I would say to myself, another day and they are not going to operate. This went on for weeks. She has no skin*, they would reply, *and she's got a sepsis. We can't do anything»*. Have patience. Be patient.

Waiting for something to happen is another way of avoiding questions that nobody, in a social pressure situation, knows the answers to. One sees the same faces week after week, building up their hopes and managing their waiting time by interpreting signs or magical practices. *Forty days, quarantine*. Interpreting banal signs like the calendar of the saints' feast days and converting any technical parameter into some kind of indication.

> *«As I couldn't bear the situation I only went at midday and did the waiting at home. It was unbearable. The daily journey to hospital was a horrendous experience. The underground never seemed to arrive. The corridors seemed interminable to me and in the lift I suffered from tachycardia. The news at one offered no hope, her fever was up, she was suffering from hypothermia, she was dying, and she was dying. I didn't want the telephone to ring in the afternoon. They told me they rang after a patient has died.*

> *In the end my friends called me only to ask about her fever. If it had gone down it was as if she was cured. But the next day the nausea returned.»*

The interpretations become more frequent because the answers provided are always terrible. Visitors get used to questioning the least bit of information, or what they believe to be information, that they have managed to gather from various snippets or from other visitors. The tactic is to penetrate the walls of secrecy surrounding the jealously guarded, seldom divulged, information. As the process is so lengthy, however, the group is able to acquire good knowledge of where to find the information and how to get it.

> *«When I got to the unit I knew that Eulalia was poorly again: the nurses didn't say good morning cheerfully. They looked at the ground, sloped off or made as though they hadn't seen me.»*

Faced with the feeling of failure that a deterioration of a patient's condition brings, the staff invents other strategies. Some employ verbal brutality.

> *«This one's about to die. They took him into the theatre today and did a botched job. It doesn't matter, he's going to die anyway.»*

Others use silent tears as they try with the benefit of their long experience in medicine to tell relatives not to build up their hopes. Others try as best as they can to cope with the anxiety induced by the suffering of patients of the same age or gender as they.

> *«When I came back off holiday I didn't dare to go into the ward and ask about Marta. When I left at the end of July I thought I wouldn't see her again. I went in and as I was passing number 12 I looked in out of the corner of my eye and there she was. I couldn't believe it.»*

These are narratives that indicate the extent of the professional self-defence mechanism.

In any society uncertainty produces cultural responses that render it highly significant. The hospital becomes a place of sociability immersed in a specific cultural context in which heightening the secrecy surrounding medical practice increases uncertainty, anxiety and desperation. Laymen therefore become blindly dependent on the curer, who is unable to manage the process well if the process does not follow the guidelines on which the model was based. As soon as the power of the curer becomes clear from a rapid and effective therapeutic protocol, the desired result is obtained. In the treatment of burns this response is neither rapid nor effective. It takes a long time, uncertainty increases and there are no answers. The blind faith is slowly and inevitably eroded; the professionals start to be criticised and time reveals the limitations and contradictions of their practice. Time also puts limits on secrecy. When in contact with the professionals, laymen begin to acquire technical knowledge that they incorporate into their own knowledge and understanding of the illness. They learn to decode and interpret medical information, evaluate clinical signs and interpret silences. Sometimes they understand the professionals, who in contrast find themselves caught in an impossible situation or trapped by their inability to share, since it is on this that they have based their practice and charisma. They still believe that if they were to reveal their secret they would lose both credibility and people's blind faith in their omnipotence, which they believe is fundamental to performing their tasks unhindered. They do not share their own subjectivity with others. Instead, they sublimate it through professionalism and scientism, believing that they do not have to admit their weakness or ignorance. The hospital Doctor does not understand that by doing this he locks himself up in solitude in a search for scientific answers that also have their limitations. In the face of an erratic and unforeseeable development his powerlessness forces him to hide behind a shield of scepticism. He accuses others of lacking emotion: «w*e've seen so many husbands (and wives) abandon their partners after their discharge; children avoid their burnt parents because they are afraid of them*», or forecasts the most negative sequelae so that at the end they are not so disappointing. His ambivalence becomes evident, however, when over and over again he asks «*the patient who has pulled through whether or not*» so much effort *was worth it*. The answer, either as a written text or as a speech in an academic or hospital context, does not serve as a mirror on which to base self-criticism «*What have you got against doctors? You're one yourself*», they asked me. I have never rejected my identity or my training. However, faced with this ambivalence they hide behind their faith in a knowledge that is also limited. Are they trying to have their work ratified, or are they asking themselves about its meaning? The social death of the patient prevents him from deciding for himself about his suffering and legitimises an interventionist model of practice that reduces him to an instrument of science. Therefore, via the permanent or temporary donation of his body, he helps other people to survive and to unveil some of the mysteries of the human body. Nurses deduce the therapeutic value of sociability and build their professional culture around it. Doctors, on the other hand, reject it because to accept it would be to question the foundations of both their knowledge and their identity.

6. Resistance

By denying the patient, and his *social presence*, *doctors can perform miracles*. The treatment of burns requires cleaning and grafting *until the patient can regenerate his own skin*, i.e. allowing sufficient time for *the patient to fabricate his own skin*. «*What you have to do*», the plastic surgeon told Marta, «*is to eat, eat and eat because you need to make skin*». As her back was used as the source of new skin, three weeks had to pass between grafts, during which time she had to be fattened up so that she could fabricate more skin. Technical operations do not heal directly: they are intended to provide the patient with the necessary conditions for healing himself. Doctors will clearly consider this difference a philosophical one since for them the healing is a result of their intervention. It is true that severe burns do not heal without the help of doctors, but this does not remove the fact that the value they give to healing is a metaphor that puts them at the top of the process. The problem is that the body responds so slowly that they have to fill the gaps between one operation and the next, one bath and the next, with significance. These gaps are presented and perceived as *the treatment of burns*, even when this time is used just to wait for the wounds to heal. These gaps reveal the limitations of their work, «*we've done the grafts and we now have to wait for them to take, for the patient to respond*». If the patient's condition is very bad, *his grafts won't take* or his skin will be *too atrophic* to guarantee their success. Their language identifies not the limitations of the technique but the limitations of the patient. If the treatment fails responsibility lies with the patient. «*He would not survive the operation*», an operation that once again has to be postponed. This highlights their fear that the patient «*will die in the operating theatre*» and place the ball in the court of the intensive care people even though any failure would show up in their own statistics.

Medical discourse merely describes what has happened. Prognosis is not changed or given overnight. They insist on *waiting* and using the patient's *resistance so far* as encouragement. These monotonous messages, rigorously controlled and expressed after weeks of disappointing messages in a corridor near the doors of the ICU, reveal their limitations. Despite the coldness, in conversations with staff or nurses one gets the feeling that they understand and have an emotional complicity. Like traditional doctors, they know their technical limitations, that it is the patient's resistance and not so much their own technique that decides between life and death. Therefore, when the patient *pulls through*, solidarity based on the waiting, anxiety and daily disappointments has silently built a channel of common feelings. It is just like what used to happen with the good old doctors.

To explain the powerlessness experienced during the gaps in time requires the process to be rationalised, the delays to be explained and the fact that healing does not result exclusively from their action to be overlooked. The patient builds his own *resistance*, day by day, hour by hour, by not dying, by getting over infections, somatic problems, and the savagery of the therapy and its side effects. *Resistance* is verified and a confused explanation linking genetic, constitutional and psycho-physiological factors is given to relatives to justify why one patient *gives up* and *dies* while another *has a will to live* and *pulls through*. How can dead beings *give up* or *have a will to live*?

Here emerge the contradictions behind the logic of the institutions that we have already seen trying to abolish cultural and social aspects. These explanations project the values of the members of staff and the doctors themselves, but their reasoning cannot be proved clinically, or else there is very little proof, or it can only be supported by their intuition. Resistance is measured by the indicators and the patient's response to treatment but such is the diversity of patients that one begins to think that some sort of communication may be established with their dead beings or that there may be some way of allowing them to communicate with the world. Again there begins a discourse of esoteric dimensions about influences. As there are no scientific data to justify such assertions the discourse is based on a strange combination of factors deriving from scientific positivism and animal magnetism and other, less visible factors that have their distant roots in the oriental religions depicted in Hollywood science fiction films. «*May the force be with you*».

With *resistance* described in this way and defined in terms of the ability of the dead being to fight and the magical influence that those who are present can pass on to him, the biomedical community, imperceptibly, finds an alibi for the limitations of its knowledge and practice. If the patient does not resist and dies «*he didn't respond or didn't resist the treatment*», but if he resists and pulls through, «*the technique* (or treatment) *is good, it has produced good results with this patient*». To perceive the sovereign body, he who is dead socially, as the fundamental agent of his healing, albeit assisted by a series of external influences that include the whole paraphernalia of biomedical therapeutics, is to rethink the whole view of magical thought and practice. This is all the more true if we add the strong ritualisation of the process, the oneiric trip associated with the pharmacological coma and that excursion to the fine line between life and death to which the patient is submitted. This process may go unnoticed in a general ICU because the stays are shorter but in burns the oneiric trip is a painfully slow process. Nothing is ever decided and nobody can guess the final outcome. The patient resists but so too must the plastic surgeon, the intensive care worker, the nurses, the ancillary staff and the patient's relatives and friends. Because of the characteristics of the process, which is a long and uncertain road, all the actors, without realising it, are constantly interchanging their roles since the emotional crisis they are involved in challenges the conventional and rational instruments that govern normal life. Finally, the notion of resistance traps the patient's whole professional and social network in the need to participate as one block in the process of influencing and encouraging the patient's resistance. However, how can one mediate in this process?

7. *Magic and technology*

How to mediate, how to influence the body somehow, is about how to influence the inner strength of the patient so that he can withstand his horrendous daily suffering. Therapeutics, antibiotics, fluid therapy, and I.V. nutrition nourish the body but the idea of resistance is concerned with the soul and in biomedicine the soul does not exist, although everyone believes that it does. There may therefore be a place in medicine for the religious idea of the miracle as the intervention of a saint or the esoteric idea of irradiation from the minds of those nearby who are capable of magically transmitting the strength that the dead beings need in order to *resist*.

Segregation of the *inside* and the *outside* becomes a symbolic limitation, with the patient located in a liminal space. For this reason the process will not be interpreted in exclusively biomedical terms but by constructing specific cultural forms in the interactive space that allow invisible communication between he who has gone to the other side and the others that are here. This space for sociability, a meeting point for knowledge and medical practices on the one hand and knowledge and popular practices on the other, was the operating theatre corridor. Every day dozens of people converged as they waited for one operation to finish or for news of another, and the orderlies made up rooms and attended to the patients' needs. Because the epidemiology of burns is erratic, people of many different origins converged on this area, sharing their experiences over long chats. Although the regulations do not allow visitors into the operating theatre corridor, they often entered anyway or *slipped through* into the hospital ward during the morning rush in the hospital services. Outside, the hospital staff never tired of repeating «*go home, there's nothing you can do here*», one never stopped hearing «*I don't want to go, I've got to stay with him, I can't go* *home, my place is here*». If the pressure is too great, they retire to the cafeteria but return later to the seats in the hall. It is a physical presence but more than that it is a social one. The patients who are admitted to the hospital may come from a long way away. In addition, in the most serious cases their relatives want to stay close to them «*in case something happens*». They cannot be convinced otherwise because they have been taught that they have to be there to share the experience of the illness with their family and they cannot go back on this principle without feeling guilty. Physical proximity is explained not only as a moral duty but also as a *presence* that directly influences the morale of the dead being. In the technological hospital this presence is a continuation of a domestic mobilisation against illness and suffering, but the hospital is not designed or organised to cater for such an area because in individualist societies with Lutheran roots this presence does not work in the same terms. As the characteristics of high-risk groups mean that most of the patients are from poor working class backgrounds, and as many of these come from hundreds of kilometres away, assuring and maintaining this presence becomes an odyssey for them, especially if the patients are burns patients. Where should they go? How should they live and how can they endure unlimited waiting that could go on for months, a long way from home and with nowhere to stay? They cheat the security regulations and sleep on the armchairs in the corridors. They do what they can to be near their loved one, challenging their own impotence, misfortune, anger and pain with their presence. Silent, unmoving, wrinkled faces in the corner. «*That's Andrés' mother, that's Ernesto's fiancée*», people explain in low voices. Atilano, Gabriel or Eulalia «*are very poorly*». These are the unknown patients half seen from the corridor through the windows that surround the ICU. They resist day after day and remind the relatives of those who are pulling through of the time when Ernesto or Andrés were Eulalia or Gabriel. If someone dies, like Gabriel, they go downstairs to hold the wake. If they pull through they talk about it quietly, almost ashamed because other patients have just been admitted. There is no need for surnames or addresses: people on the inside will hardly ever be seen again. His wife is out now, she's suffered so much, but «*Miguel is still inside. He's getting better, though. How courageous his wife has been, they are saying here that nobody can work out how she survived. We've prayed a lot for her*». The only information people have are first names or the number of the patient's bed. The number of anonymous experiences gets bigger. The experienced ones approach the "newcomers" who look despondently at the floor and feel jealous of those who come out smiling. But the latter look for an opportunity to say hello to them, to break the anonymity and privacy to engage them in conversation and encourage them, «*you must be*

Eulalia's husband, I know how your wife is, here bad news gets around fast. I know she's in a bad way but have faith, keep your chin up». Then they recount their own story to show that some people do pull through, or speak about Eugenio who was in two years ago, or Atilano, as if they were legends for pulling through. «*Don't lose faith, keep your chin up*». Stories with a moral to fill the void left by the uncertainty and show that there is light at the end of the tunnel beyond the doctors' cold assertions and their lack of prognoses. At the same time the stories become lessons in how to behave when one day they may be able to do the same for those who are admitted in a critical condition a week later. Local myths, legendary people, short personal stories; the small, miserable odyssey of one on the outside so that newcomers may know what they must do, how they must resist, how they got through the days and nights of frustration despite the absolute powerlessness of waiting.

In desperation nausea invades the body. It becomes a shield that prevents one from thinking rationally. Sometimes it leads to nihilism.

> «*I didn't want to see her like that, I wanted to remember her as she was when she was alive. Everybody said she'd die, but I never accepted that. The worst thing was my feeling of impotence, everything I knew was useless, and I could only use it on myself. I must resist so that I can be of use later. I didn't know then how useless I was going to be.*»

Nothing can rationalise the situation and one begins to believe in the comfort that religion brings to people.

Professionals and lay people regard the resistance of the dead being as a conscious struggle against death – a struggle that allows those waiting to live in hope. The crisis situation therefore creates imperceptible communication links between all the social actors, the *social presence* of the patient must not be just a symbolic one: it needs to form part of the therapeutic process. Presence alone is not enough: action is needed. To accept this implies a discourse regarding the patient that hides the work that the patient's relative does for him and creates a scenario in which the social network must be aware of doing something for the patient without accepting that they are doing it. The bells toll for you.

> «*I don't know if you are religious but I spend all day praying for my husband. It's the only thing I can do for him. I have great faith in saint Gemma Galgani, many people here in Achúcarro are devoted to her. She's performed miracles and intervened for many patients*, says Vicente's wife. *I'm agnostic, you know, an old agnostic rationalist, but many nights I have prayed and prayed, relatives of other patients gave me religious pictures and I kept them at my bedside* (8).»

In this context of human intervention, belief in miracles does not arise from superstition or ignorance: it is an instrument that takes on a new meaning in a context in which the limits of what is human or natural appear to come into focus. It is important to believe in them because doctors, attempting to get away from the pressure of relatives, can be seen rushing along the corridor saying something like «*he's going to die, he's going to die, he's got some terrible scars. One can only pray and hope for a miracle*». Why a miracle in this temple of reason? The word does not crop up in the treatment of burns only occasionally. One always hears it. It is at the forefront of the process. It expresses the chance that all burns patients have when they are admitted but that is not formally invoked. The miracle is present. The doctors not only utter the word: it is embodied in the corridors and in the wards. Healing the badly burned patient is a miracle that challenges the very limits of science. The social actors, whether professionals or non-professionals, think or sense that they can participate, that they can intervene. The social body merges with the individual body.

> «*We don't really know why he pulled through. Everything was against him. We didn't even dare to do some things because we never thought he would resist. Sometimes it happens, it just happens*, says the head of the unit. *I'm an agnostic and an apostate, but I don't know how many times in desperation I asked for forgiveness and tried to say prayers I only half remembered from my childhood. I collected religious pictures and made vows. I had to try it, I just had to, both for my patient and for myself.*»

The belief in miracles is the consequence of the long waiting, the time of uncertainty, the time without answers, the feeling that one can do nothing. All this means that there is nothing left to do but search desperately for something to hold on to in order to feel that one is taking part in the process and limit the effects of the nausea in oneself. In these contexts the social network of patients, even those who are not religious, openly rebuilds belief in the symbolic efficiency of religion and magic. This sometimes leads to a blind faith in new technology (which often borders on science fiction), promises to our Lady or the saints, magnetism and the effects of electromagnetic radiation from the brain, telepathy and telekinesis. *Look*, Juan's wife tells me in the corridor leading to the operating theatre when I tell her that I do not want to go in to see my wife because if she dies, I want to remember her as she was when she was alive.

> «*I go in every day and touch my husband's bed, strongly, very strongly. I know that in this way I transmit all my energy to him. When I'm here I do the same. I know he receives it and it helps him.*»

Juan's wife is a devotee of saint Gemma Galgani. She has given me pictures of her, she prays every day, and she is a believer and regularly practises religion. However, she does not realise that she has incorporated the ancient resource of thaumaturgical touch into her religious practice, which is based on requesting intervention, and that she has reinterpreted this in terms of telepathy and energy. She prays in the hospital chapel, far from her husband, but she needs the physical contact to say to the dead being: I resist so that you may too, and my resistance, my will to live, is my will that you live. The metaphor they use is a biological one that in the sophisticated hospital reveals the strange relationships between medicine, religion and magical thought. This energy is transmitted telepathically or physically (it is therefore necessary to be present) by touching the patient or his bed or, sometimes violating internal regulations, by bringing objects into the room.

> *«As I'm a rationalist with medical training I preferred the classical resource of religion, prayer and vows. I couldn't get to grips with all this paraphernalia connected with telepathy. I suppose I'm too radically positivist and too sceptical. However, I still don't understand why I took up the old religious discourse of my childhood again. Perhaps at one time in my life I believed in it and it seemed now, in my desperation, easier to accept than parapsychology.»*

An innocent observer may think that the magical and ritual practices that hospitals follow are a consequence of the divide between knowledge and ignorance, that they are secondary adaptations on the periphery of the hospital. In the first draft of this text, I fell into the same trap. Later, however, I realised that religion and magic did not represent the boundary between the *inside* and the *outside*. Neither were the product of people's superstitions or ignorance, but rather the output of dialectics between scientific and popular knowledge located between the organisational culture of the scientists and the social presence of the patients. Magic and religion were therefore fundamental to structuring the organisational culture of the hospital as a product of the interaction between the staff and the patients and their social network, between the hegemonic culture and the subordinate cultures. The culture of magic and religion is built around experience and characterised by dialogue. Because the ability of the technological hospital to fulfil the purposes for which it was designed is limited, it has been impossible to exclude this culture from it.

What I was able to deconstruct, as an observer, made me realise that the dividing line between magical thought and religious thought is not the one that separates the *inside* from the *outside*. Professionals themselves have, in their own way, incorporated these thoughts into their own practice, their own management criteria, and their requests for help and mobilisation. Also, behind their shield of technical knowledge, they have channelled them and re-fed them. Otherwise, how could a professional remain for years and years in this service, witnessing all this horror, when most of the resident doctors escape after their compulsory working period to pursue their careers doing breast and nose jobs in the private sector? Why else would they stay there if not out of a subjective confidence in their mission?

It is because they themselves recognised and invoked those miracles in which they could claim to be mediators.

Both magic and religion are participants in the process because the process implies the emergence of a shared logic. While the magical and ritual practices play an important role in the process of enduring the waiting, their effect is to improve the relationship between the *inside* and the *outside*. For this reason, from the inside the miracle is invoked and practices to support it are encouraged. I am not saying that invoking the miracle is a conscious strategy on the part of the professionals but it is the product of the *external* condition of specialist that emerges in a crisis situation. The miracle is invoked because many doctors and nurses are believers and they believe in them and because they are not fully able to give a reasonable explanation for the differentiating factors behind the *resistance* of the patients. However, whether they are believers or not, when a seriously injured patient *pulls through*, they rationalise their therapy and cannot explain with assurance what it was that allowed the patient to survive. In the annals of the burns units there are constant reminders of cases of mythical proportions of patients who have survived. Singular cases when no hope was left. Cases that, in a cultural context like the one I am describing, take on the same structural function as those that were resuscitated or cured of fatal illnesses in the miracles. Both types of narrative are designed to establish the symbolic existence of hope in an environment in which, rationally, there is none.

In these circumstances religion and magic acquire a highly significant role in the logic of the institution. They become incorporated as subordinate practices in therapy and care, set up an area of sociability and turn the patient's social network into actors in the therapeutic process. This is why the professionals, when the situation takes them beyond their condition as professionals and their human dimension emerges, propose or resort to the metaphors of magic and religion or think about them without mentioning them. To a certain extent, in the area of non-sociability, they also express a desire for sociability that allows a degree of participation.

> *«As they knew I was a Doctor, although they would have always denied that I was, that night they asked me to give them a hand with Angela, the dressmaker from Vallecas. She was the daughter of one of the patients and didn't want to leave the hospital. That day I felt particularly useful. I managed to convince the girl to go home: I told her what had happened to me and other stories people had told me. I didn't have to make it look as grim as the doctors had always made it look to me and to her. We spoke for a couple of hours. She went home then without the feeling of guilt that had at first prevented her from leaving her father alone in the ICU.»*

However, the resources of magic and religion have some obvious limitations. They become more and more apparent as the relative, extending his knowledge of the process, begins to understand that all the doctors' efforts are worthless if the patient does not resist. This point highlights the failure of the institutional model and the need to find an explanation for what has happened. The relative, besides praying and transmitting energy, begins to perceive the Doctor as someone who is unable to provide answers, because he has none, and who, like the family doctors of other eras, can at the best of times only make predictions. He therefore asks the doctors to do what they did at the patient's bedside in the 19th century i.e. allow the patient to die well, share his suffering or share the waiting. Moreover, the Doctor can only offer partial answers.

Doctors have abandoned their role of providing social support for patients and their relatives but they have not resolved the questions surrounding uncertainty. Popular knowledge to fill this gap is built up not through medical discourse, but through occasional botches created by the syncretism between magic, religion and science, or by legendary stories of patients that prove that survival is possible, that there is a future. This is why, when the patient is about to pull through, the staff oblige the relative to enter, *«you must go in, you must, he's waking up and he needs you»*. The patient needs the final push to resist, the relative needs to transmit to the socially dead the stimulus of society, a reason to be reborn and end his odyssey at any price. *«The sad thing is that when we on the outside cheer because he's pulled through, his own drama will be only just beginning»*, said someone, with the strange lucidity that the desperate waiting brings.

8. *Pulling through*

Sometimes a critically ill, badly burned patient *pulls through*. This does not mean that he comes *out*, as he may remain *inside* for months and even die. *Pulling through* means that the patient crosses a symbolic threshold beyond which his survival *seems* assured. Those who *pull through have resisted, have turned the corner*. It is the result of changes in clinical indicators, improvements in biological parameters, intuition, experience and subjectivity. It means that the living dead revive or are reborn, that they can return to a social life, although they are still not cured.

> *«I was envious whenever anyone pulled through and I wondered when it would be my turn. It was for me that the bells tolled, not for her. Will I be able to forgive myself one day?»*

In a context in which the border between life and death is not clear, those who pull through acquire a charisma. The whole unit has taken a gamble that will link them to the unit forever. Quite apart from their inclusion in overall survival statistics, the singularity of these exceptional cases inscribes them in the annals of the institution's culture. They become its points of reference, prove its efficiency, cement its prestige and are presented at professional meetings. However, for the journey towards pulling through there are no explanations. It just happens.

> *«Halfway through the month she was dying. They hadn't bathed her for a fortnight. The nurses told me she smelled. Friday was the public holiday in honour of our Lady of La Paloma and you know what public holidays are like in hospitals, staff is off and, well, you know. The nurses said that the more sedatives they gave her, the lower her temperature got. They bathed her on the Sunday because they thought that if they didn't she would die. They couldn't wait any longer. They took a gamble. Her hypothermia after it was incredible. I was told her temperature was 29º and that she had a pulse rate of 250. By Monday her temperature had increased a little. They took away her sedatives and her temperature seemed to go up. That week it was the procession. Her friends had gone to see it. Luisa carried the candelabra of the Virgin and pinned a brooch of our Lady to her chest. She wore it all night. They brought the brooch to me in Madrid on Thursday and I gave it to the nurses to put in her room. On Thursday they bathed her again. One nurse told me that it had done her the world of good. On Friday, her temperature was being back to normal and the nurses insisted she was getting better, she was better, and she was waking up. The doctors began to speak in a different tone of voice. On the Saturday we went to see her. When I went in and she saw me she started to cry. She knew who we were. On Sunday for the first time the nurses said amongst themselves that she was pulling through, she was pulling through. And she did.»*

Nobody asks why someone pulls through. As the answers are unclear it is better not to look back. The gods forbade Orpheus to look at Euridice until they got out of hell. Here hardly anybody looks back. Hospital statistics do not explain the reasons why. They are diluted among all the patients in the unit and reduced to statistical correlation of biological and sociological variables. «*She simply didn't want to die. It was fate. It wasn't her time*». Again they talk about genetics, constitution, the will to live and resistance but after this period of uncertainty they feel sure of the practice once again and pulling through is seen less and less as a thing of the patient and more the result of the technical measures deployed. There is no more talk of waiting or of miracles, but of being patient, of being a good patient, of following doctor's orders. Once the patient has recovered his leading role, his social network abandons its vigil.

The story of the brooch of the *Virgin* is only told to the closest friends.

> *«You never know how to explain these stories because some people would look down on you, my God, miracles in the 20th Century! You think some people will have a good laugh behind your back.»*

Lay people, while congratulating the relative on his happiness, talk about *«fate»* or say that *«nature is an unfathomable thing»*, or that *«it wasn't time»*, others reply that *«this kind of thing makes my hair stand on end»*, while others think the story is *«beautiful»*. Patients prefer not to speak about it. It has nothing to with them: it is all about the work of others.

The point at which patients pull through is on a symbolic line that divides life and death and has different interpretations for the different social actors. For intensive care staff and nurses it means that their work has been a success. For close relatives it means the end of a period of uncertainty and distress and their return to a world of care and conventional hospital support and a chance to help the patient physically. More distant relatives feel that all has ended well, so they can be demobilised. For the plastic surgeon, who recovers complete control over a patient he had previously shared with the intensive care specialist, nothing visibly changes. For him, pulling through means that his job is done and that the last ulcer has healed: *«you are no longer a burns victim, right now you are a patient of the plastic surgeons»*.

For the patient it means nothing (Allué 1996: 17). He does not know that he is entering a new stage in his life from which there is no escape. The New Testament teaches us about the resurrection of Lazarus, but it does not tell us what became of him. The burns patient does not know what future lies in store for him either because nobody tells him. The plastic surgeons have lost track of their old patients and have done their part of the job. Now the patient is shared among rehabilitation staff, orthopaedists and occupational therapists. Relatives are also in the dark. The club of severely burnt patients is a select group of *revenants* who do not know each other and whose later stories, in so many social arenas and with so many different sequelae, have peculiarities that are difficult to share. The badly burnt patient who survives is a special case. Fire is a capricious thing. Sequelae manifest themselves progressively, sometimes months and even years after they have *pulled through*. Rehabilitation may last years and may be a life-long thing for some parts of the body. Aesthetic sequelae change and diminish with time, but the functional sequelae and disabilities mean having to learn to eat, walk, dress, or put on make-up. They mean taking on a new identity. These are permanent areas of uncertainty for which the patient has no previous experience.

For the hospital service the patient who pulls through is another success to add to its list of triumphs. It justifies the goodness of its therapy and organisation. They present their slides at conferences, write a few articles that may guarantee them future successes. The life of the patient is no longer a matter for them. For a few years some will be landmark references until their names are forgotten and replaced with others. They will then become clinical records in some storeroom until the papers are destroyed or read by some medical historian. After five years these articles are no longer read, they are the scientific prehistory of treatment. The patient, *who is no longer a burns victim,* begins a long journey of rehabilitation and plastic surgery, during which his singularity is lost. Now he is another elbow or contraction or a few more tendons. Out of professional curiosity they will explore the whole body. As usual they will touch and pinch the skin and evaluate what their predecessors have done and, if necessary, criticise their work.

The story of the Virgin also is forgotten: it is just a private anecdote that has no interest for religion. In the burns unit, just as psychiatrists behave like surgeons or intensive care staff, the priest goes around dressed in a doctor's coat and behaves like a psychiatrist. The Church is not interested in these miracles. It is as reticent about them as it is about the healing that takes place around apparitions. The matter is not even remotely discussed within university hospitals. Our Lady and the saints do not need to be legitimised further. To argue about it would mean reopening the old controversy between science and religion. The Vatican accredits miracles based on post-mortem medical reports and beatification requests, which in recent years have been particularly frequent and quick. The miracles performed by the apparitions of the *Virgin* Mary and the saints had some meaning in the fourth century. Today they do not perform miracles. Miracles are performed by men and women who the Church wants to beatify in terms of the new meaning that it attaches to the word to defend itself against the generosity with which saints were beatified in the beginning (Woodward, 1991; Ziegler, 1999). The relationship between religion and medicine also requires accepting scientific discourse and using rationalism to administrate some of the educational or sanitary measures without creating any conflict with medicine. In exchange, the Church does not question the healing ability of the doctors because its strategy today depends only marginally on this as an instrument of faith. The theological miracle today is no more than what medicine is prepared to accept it cannot explain. Religion has also taken on board the medical model: the priest does not take part in the ritual and magical practices we have previously referred to.

However, while the relationships between medicine, magic and religion can be understood in terms of their respective organic roles in modern society, they become especially significant in the hierarchical hospital. Here, the social use of believing in miracles allows the limitations of science to be exonerated without its overall validity being questioned. It also allows the professionals and their institution to be made unaccountable. This is also true for the patient's social network, which is allowed to play the symbolic game of supporting and contributing to therapy although they are not told that this symbolic and ritual game is being played especially on itself. For religion this no-man's-land highlights the strong influence that it still has on popular culture and represents an area in which people's faith, which is minimal when compared to other eras but not insignificant, can be restored.

In hospitals, medicalisation has not brought about a process of demystification but a reordering of hegemony and subalternity. The hospital practices we have described show this. The difference lies in the subordinate position of religious discourse in the institution. Its fundamental role is to administer sociability at the heart of the institution. Praying for a miracle is relegated to the intimate, to an occasional role in making more tolerable those situations that institutional care, having reduced illness to a biological dialectic between patient and professional, has not foreseen. In most societies this dialectic is wider and biological illness is included in a social and cultural experience that extends invalidity beyond the biological patients to their social networks. Therapy and care take care of both groups. In the traditional model this was one of the functions of the social support: it wished the population to accept science rather than pure faith, to replace the religious interpretation of illness involving the mystery of God with a naturalist one that offered the immediate and perceptible support of men.

This support does not exist in the hospital model so the patient's social network and the hospital workers themselves use religion and magic as instruments to bear the personal and collective crisis and to combat uncertainty. They resort to the miracle to express what they cannot explain rationally. The miracle becomes a functional tool, in the sense that it helps resolve uncertainty, the lack of answers, ignorance and anxiety. The hospital staff uses the miracle as a resource that is not foreseen in their therapeutic arsenal.

The limitations of this magical practice and its link to those *on the outside* and to the hospital staff can be seen when those on the inside, the patients who are pulling through, are unwilling to accept the hypothesis. They have not resorted to magic because it is not one of the expectations that they see from their perspective. The patients learn very quickly that such a miracle does not exist, although they may wonder one day what it would be like. In Lourdes there are crutches, but no prostheses. Their functional and aesthetic sequelae are going to shape their new identity. They have died and they have been reborn but they are not the same.

This is why one can also understand both my agnostic and rationalist informant and my informant who has prayed for his family offer candles: they make pilgrimages or cling to lucky charms to keep the promises they have made to their relatives and friends. The bells toll for them, not for the patient who may now be handicapped for life. This is why we can understand the patient, in as much as he accepts his new identity, considering various scenarios that fluctuate between depression and suicide. Why does he bemoan his misfortune? Why does he say *«now it's up to them to keep me?»* Why does he embark on a struggle and personal resolution to completely restructure his life and, in a new form of civic responsibility, take on a new identity that is neither better nor worse, just different?

9. *Euridice*

I do not believe in miracles, but they do exist. I shall conclude this ethnography at the point where Euridice recovers her *presence* and affirms her social being and her freedom. Her own ethnographical narrative describes the facts of the latter stages of her journey because pain and physical suffering cannot be shared and we probably do not have the right to share them anyway (Allué, 1999). Between the moral suffering of the staff and relatives and the physical suffering of the patients, staff and relatives always come off better. It is the tortured ones who must talk about it. For this reason I do not want to talk in terms of concluding my account. I have attempted to put forward an ethnography based on a *tranche de vie*. It is the story of a couple of months in the life of an observer who in hospital changed his role of temporary patient to those of husband and witness of a great drama. This observer is also a psychiatrist. Only the distance that time provides allows him to take up the role of anthropologist.

I have not attempted to be objective in the naturalist or positivistic sense of the word. What I saw, what I lived, may be perceived as the revenge of an ingrate or the settling of scores by a traitor to his profession. Perhaps it will be read and will allow similar scenes and similar situations in other small units of other enormous hospitals in other parts of the world to be relieved. Either way would mean that the consciences of its readers will have been moved in one way or another. If I achieve this, I will have met my objectives. An ethnographical account can never claim to be an objective representation of reality. It is the reader who awards veracity if it fits in with his own perceptions, emotions or intuition. An account wishes veracity to stem from the embodiment of another person's experience: «*that was my experience too, just as you describe. When I looked after my mother, or my father, or my friend*». On the other hand, when someone spits out: «*so that's why we pay you, is it?*» I do not feel like a traitor to the medical profession that I have never abandoned. My position in all this has been extremely ambiguous. In my narrative, my identity as an anthropologist has come through. My function in the hospital was more than that of a companion, or that of a Doctor who fails to understand why he is living with the subjective and undying awareness of his mission in the world. In the first draft of this text I may have been obsessed by the need to keep a distance, to remain objective. These needs meant that I had to hide the part I played in the events (and my misdeeds).

Five years later my position has changed. I intend to hide neither the part I played nor my misdeeds. However, I can comprehend and explain the Orpheus myth. I understand now why Orpheus looked at Euridice and why she comes back to hell. The Euridice he went to find and who died under his gaze was the woman he desired so intensely to see. However, it was a different Euridice who left hell with Orpheus and it is she who now tells us the story from her point of view. She is the myth's real heroine, not Orpheus. She defeated hell. Both she and Orpheus left it and were able to live together once Orpheus had understood the greatness of Euridice's new identity and accepted that his failure guaranteed their future and was the means to fulfil his uncontrollable desire that led him to go back to hell for her. The importance of the myth and of this story, therefore, are not its heroes but the way in which men and women build their own versions of hell and are reluctant to leave them.

> Roxanne: «*Ces pleurs... c'était vous?*»
> Cyrano: «*le sang était le sien*».
>
> (Edmond Rostand 1912, *Cyrano*, Act V)

Notes

(1) This article is part of an ongoing investigation into the relationship between medical practice, self-care, institutionalised care and religion. Fieldwork was carried out between July 1991 and February 1992 in the burns unit of a hospital in Madrid. Other observations were made over periods of no longer than two weeks when accompanying my wife to a burns unit in Barcelona between 1993 and 2000 and to a plastic surgery department of a hospital in Galveston, Texas (United States), in 1993. A first draft was published in Comelles, 1994. This paper is more enlarged English version of the Spanish text (Comelles, 2000).

[2] The skin makes up 15-20% of body weight and, in an adult, has an area of just under 1.5 m^2. Infection of a seriously burnt patient is essentially caused by opportunistic flora in the hospital.

[3] A graft is a layer of skin extracted with a dermatherm and applied to the debridement area, either as a complete graft or as a mesh to stretch the skin over large areas. Grafts are not intended to become new skin but to act as anchorage points or as a "catalyst" in the granulation process.

[4] Not all donor skin is of the same quality. The good skin is found on the thighs, the back and the pubis. It is better in men as it is more robust; in women it is thinner. In the initial evaluation the plastic surgeons always touch and pinch the skin. The relationship between the plastic surgeons and their patients is a constant game of touching and pinching. These physical relationship forms the basis for clinical experience, «*stabilised skin is skin that can be pinched*», they say, but it is also a part of the interactive game between the plastic surgeons and their patients. There are strong elements of reification, however: «*tell me what you think of this ear*», says one doctor in front of a patient who is conscious. Or, *that nose will be very bad*. It is not often that one hears, «*his nose might not be very good*», for example.

[5] The idea of *El Corte Ingles* – the biggest department-store in Spain –, comes from the mesh-type grafts. To cover large areas it is not necessary to apply full skin. An extendable mesh of skin obtained with a dermatherm can suffice. This can increase the area to be covered three- or four-fold. This type of graft is identified in the healed skin by its appearance – it is like a wide gauze mesh.

[6] While doctors never concern themselves with this matter the nursing staff, who are much more frequently in contact with the intubated patient, are much more sensitive to the patient's condition as a living being. It must be remembered that pharmacological coma is maintained through synthetic opiates and is subject to peaks of maximum drowsiness and troughs due to the kinetics of the drugs. Moreover, the dreaming that opiates usually generate contributes both to this fluctuation between deep sleep and semi-conscious daydreaming and a certain perception of the body being handled (see Allué, 1996: 24-40).

[7] There are clear differences between Spain and the United States in this respect. The need for the informed consent of the patient demands that the patient be able to designate a representative who can take decisions in certain circumstances on his behalf. In Spain this is not completely regulated. What we may call the common right of the opinion of the social network is in operation.

[8] Gemma Galgani was an Italian member of a religious order at the beginning of the 20th century. She died after a long and painful illness and was later beatified for her ability for miraculous intercession.

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 289-310

Crossroads between transformation and stability.

Hospitalisation in Finnish cardiac care as an example

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Introduction

Coronary heart disease (CHD) is a major public health problem in Finland. In health care the procedures dealing with CHD have been standardised as a cardiac chain of care. My aim (1) is to analyse a part of this care, the treatment of acute myocardial infarction (AMI) in a modern hospital, by using the concepts of the rite of passage and liminality initially formulated by Arnold van Gennep (1960) and developed further by Victor Turner (1968, 1977, 1978). I will argue that in certain respects the treatment of AMI can be viewed as a ritual passage intended to transform both the individuals who undergo it and the community that has designed it. The use of these concepts in analysing hospitalisation and the experience of biomedicine has been suggested by Davis-Floyd (1992), who argued that hospitalisation is a modern rite of passage during which essential features of American culture are communicated to birthing women, and Alan Radley (1996), who suggested that bypass surgery is a kind of liminoid period during which medicine leaves its mark on the biography of the sufferer. Although these concepts are useful in analysing the ritual structure of the treatment as a passage and the transformative work of liminality, they are too general to account for the predefined roles and the rules of face-to-face interactions in a modern hospital setting. From a ceremonial order point of view (Strong 1994), the hospital institution sustains the status quo instead of aiming at transformation. I will look at how these different perspectives are intertwined in the treatment of AMI. From the sufferer's point of view the experience is reflected at three different levels. First, the relationship between the self and the body becomes uncertain; next, the view of one's agency and subjectivity in everyday life is scrutinised and, thirdly, one's relationship to the institution and the society at large comes under consideration.

Contextualising the care of acute myocardial infarction

Coronary heart disease (CHD) (2) is a major public health problem in Finland, which causes1/3 of all deaths (3). Actions ranging from large-scale health educational programs to investment in medical high-tech have been taken to reduce morbidity and mortality from CHD. Medical and societal interests are intertwined in the efforts to deal with a major illness and cause of death. The emergence of the medical category of CHD and its treatment were closely related to the rapid development of medical technologies and especially medical visualisation techniques. Although dating from the 19th century, the electrocardiogram was used more extensively in the 1950s to map the incidence of CHD among the population. In the 1970s it was widely used in hospital settings. Angiography and ultrasound techniques were introduced in the 60s, bypass surgery in 1970, and the use of betablockers and calciumblockers in the 80s marked a turning point in the treatment of CHD. At the same time, population-level studies of risk factors made high blood pressure, cholesterol, and smoking the prime suspects for atherosclerosis. (Siltanen 1990).

The rapid expansion of medical knowledge on heart disease coincided with the emergence of the welfare state in Finland after the Second World War. The exceptionally high rates of deaths due to cardiovascular diseases was publicly acknowledged and defined as a major public health problem to be combated. The problem was not merely a medical one but also concerned social issues like working capacity and support for the sick. In 1955 the Finnish Heart Association was established (the second in the world after the U.S.) to combat “the societal-medical question” by establishing co-operation between citizens, doctors and institutions. It recruited volunteers from all levels of society to deliver “accurate information” about heart disease to the public. It also arranged social support and rehabilitation courses for the sufferers. Later, as these problems were taken up by the emerging structures of the welfare state (4), the association stressed prevention of heart disease by arranging health educational campaigns and providing education for medical personnel (Teerijoki 1990).

One important way to combat the problem has been the development of a cardiac chain of care by health care officials. Basically this represents a way to unify the treatment of CHD by creating standards of care and by delivering the responsibilities and actions to be taken between general practice (perceiving risk factors and prevention) and specialised health care in the hospital (like the treatment of AMI or bypass surgery). In the current attempts to develop the cardiac chain of care further both major means of controlling CHD are being emphasised; managing the body by hi-tech used by experts and the individual taking responsibility for his own well-being. Recent developments like the use of troponin markers in diagnosis have resulted in a more accurate diagnosis of AMI as well as more efficient treatment, such as angioplasty. Cardiology's success in managing the physiological processes by the use of hi-tech and visualisation techniques make it a good example of the ability of biomedicine to save lives (at least on the popular TV shows). At the same time the emphasis put on prevention and education about risk factors is in line with the more general cultural atmosphere valuing the importance of being healthy. I am interested in how these seemingly contradictory trends are brought together in the treatment of AMI.

I wish to use this brief contextualisation of CHD as a public health problem as the background to my analysis of the cardiac chain of care as a ritual. The cardiac chain of care, built on both biomedical and welfare state principles, highlights some crucial aspects of how the problems of illness and death are met in Finland. The implementation of the cardiac chain of care in institutional structures is a way of symbolically portraying certain key values and cultural orientations like the value of technical control of the body and a healthy lifestyle. The cardiac chain of care also mirrors social relationships by making explicit the responsibilities between individuals and actors both in health care and everyday settings. However, as Turner has emphasised, a ritual also has a creative function in that it 'actually creates, or re-creates, the categories through which men perceive reality – the axioms underlying the structure of society and the laws of the natural and moral orders' (1968, p. 7). In order to analyse how these functions are realised as reflections on body, lifestyle, and social relationships, I will concentrate on how AMI is treated in a hospital setting (5).

A cardiac passage

An important category of ritual, first suggested by Arnold van Gennep (1960), is the *rite of passage*. A rite of passage is a transitional ritual accompanied by a social movement from one status, place, or state to another. All rites of passage are based on a three-fold model: separation, the margin or limen, and reaggregation. In the separation phase the ritual subjects are detached from their old places and statuses in society. In the limen the ritual subjects are outside the established social structures and are metaphorically identical with the dead and infantile. In the reaggregation phase the subjects are installed, inwardly transformed and outwardly changed, in a new place in society (Turner 1978, p. 249). The idea of a rite of passage is to transform, to change the whole person, including the nature and destiny of his body.

Robbie E. Davis-Floyd (1992) has applied the concept of rite of passage in the modern hospital context in her analysis of standardised technocratic birthing procedures in the U.S. Hospitalisation initiates the mother and child into American life, effecting the movement to the status of a mother. As one of the most powerful rituals acts in contemporary Western culture, the hospital birth as a technocratic rite inscribes the values of a technological culture into the bodies of birthing women and their new-borns. Following Davis-Floyd's argument on hospital birth as a rite of passage, I will look at how the institutionally organised treatment of a heart attack resembles van Gennep's three-fold model. On his journey through the hospital the patient moves from emergency unit (separation), through the cardiac unit (limen) to the medical ward (reaggregation).

> «A nurse guided a man to the emergency room. He looked greyish and grasped his chest. Another nurse calmly guided him to the bed; asked him to undress and handed him faded brown pyjamas. She put his clothes and belongings into a plastic box for storage. Then she started to connect the man to the monitor, which measured his blood pressure, saturation and pulse. At the same time she briefly asked him about the onset and severity of pain. Then she ordered the man to lie still and quiet as she started to take the electrocardiogram. Calmly but quickly she called in the Doctor, who took a glance at the ECG, listened to the nurse's report, and immediately ordered the nurses to take blood tests and to start a treatment called actilyse to dissolve the apparent block in the patient's artery. Then he went to the patient, introduced himself, asked a couple of questions, listened to his chest with a stethoscope, and said that he had a cardiac infarction. "We'll take care of that, you just have to stay still and tell us if the pain gets worse." For 15 minutes 3 to 4 nurses were working around him, taking blood, taking an x-ray, giving medicine, talking to each other in medical language. For an hour or so a nurse constantly kept an eye on him writing down carefully what the monitors reported. The patient was quiet and his eyes were shut for the most part».

The emergency room is a place where medical cases needing immediate care and hospitalisation are sorted out from all other kinds of health problems as well as social problems and various demands brought into the clinic (Dodier & Camus 1998). It is a threshold between society and the hospital. In the process of selecting and admitting patients into the hospital, the social and personal characteristics defining a person are replaced by redefining him as a medical case according to biomedical categorisation. AMI is a good example of a life-threatening condition needing instant medical intervention and the shift between categories is usually rapid as in the above extract, where there was no need to consider the man's claim for care or his social attributes. People with chest pain jump the queue, and the diagnostic measures are started immediately. Initially it was the man's body that separated him from everyday life, as he was not able to go on with his daily routines any longer. When he was admitted to the hospital this separation was institutionally marked and increased by the non-ordinary world of the clinic. The changing of clothes and restrictions of bodily movement, the emphasis on visualised bodily processes, and the supremacy of medical logic all symbolically marked his separation from his previous social states. His problem was reduced to his body, a blocked artery.

From the emergency room the patient is transferred to the cardiac care unit, the limen in Gennep's terms. Here the patient is literally and symbolically somewhere between life and death.

> *«In the office, the bed number told me that there is an 'infarction' in '0-1'. I went to the intensive care unit. Amid all the monitors and technical equipment lay an older lady looking lost and tired. The monitor made a beeping sound once in a while because of her low blood pressure. She said it had been difficult to sleep here, as the night had been restless and noisy. The nurse and I started to do our morning routines. We washed the lady in her bed; 'hasn't happened since I was a child' the lady tried to joke, the nurse wrote down her blood pressure, etc, counted carefully what had gone into and what had come out of her body during the night… During the doctors' round four doctor's showed up. One of them asked how the lady was doing. Then he turned to the other three and started to explain that she had had an infarction yesterday, there was reason to think that three of her arteries had been partly blocked. The conversation about lab tests, medication, etc. went on using strictly medical language. Meanwhile the lady stared at the ceiling. After a while the Doctor turned to her again, recounted some of the blood values, and said that they've planned to change the medication to see if they could stabilise her blood pressure… Later she asked us (the nurse and me) for permission to move her leg a bit as it hurt… I was afraid to ask her questions dealing with anything outside the immediate situation and felt that it was easier for me to stare at the monitor than look her in the eye. The nurse seemed to know even less about the lady's life outside the realm of intensive care.»*

> «In the CCU the patients are defined primarily in biomedical terms. Monitoring and controlling the bodily processes became the main focus of action of the medical staff. This was in striking contrast with the agency of the patient, whose body became the target for action instead of being the agent. Actions focusing on bodily processes and technological equipment bypass the patient as a social being. Although nurses are 'present' (keeping an eye on the monitors) all the time, talk is often limited and issues beyond the immediate situation are avoided as they might worsen the patient's condition. The nurses often talk of their patients as 'not being themselves' or 'in a state of shock' thus emphasising that they are dealing with people not fully responsible for their actions or speech. Being hooked to the wires, lying in a corpse-like position, all bodily processes carefully counted, being

> treated like a child, not able to move all emphasised the patient's detachment from normal interactions.»

The third phase, reaggregation, begins when the patient is moved to the medical ward after the "vital bodily functions" have stabilised. The patient's bodily processes are still monitored but not with the previous rigour and use of heavy technology. The emphasis is now on secondary prevention, which includes conveying information about coronary heart disease and the main risk factors (smoking, diet, and lack of exercise).

> *«I went to see Antti, a 50-year old man, in his room, which he shared with three other men. Monitors or other technical devices no longer surrounded him. He sat on his bed. He had just been walking in the corridor after being encouraged by the nurse to get used to moving around again. First he was allowed to go the toilet in his room, then to the corridor, and maybe tomorrow he could visit the canteen on the second floor. He told me how he had had a conversation with the nurse (Antti's wife was present as the nurse had invited her) about how to reduce risk factors in order to avoid another attack. Antti had difficulty in understanding the point as to his mind he had been eating healthy food with low fat, he didn't smoke and he had exercised enough… During his stay at the medical ward he got booklets about cholesterol and diet, a booklet called "Life after a heart attack" including information about the disease and medication, information about rehabilitation courses, filled in a psychological test in case he wanted to take part in one (which he didn't), saw a video about coronary heart disease and another one on exercise after an attack.»*

This remarkable change in emphasis from technological control to delivering information about prevention is coupled with mobilising the patient from being a passive recipient of care to an active processor of that information. The patients are expected to actively absorb the facts about risks into the idiosynchronities of their own lives. In order to facilitate this, nurses try to establish rapport with their patients and discuss their social roles and the details of their everyday lives, from going to the shop to sexual life. The patient is being shifted from a medical case back to a person with social attributes. This is not only done by discussing information on risk factors, but is accompanied by restructuring the patient's agency in relation to physical movement and social relationships. After lying still for a few days, the patients are encouraged to move again little by little and detailed instructions on how to move and exercise are distributed by the physiotherapist to overcome the fear of moving again. Social relationships are introduced by discussing the daily lives of the patients as well as by inviting spouses or significant others to take part in the discussions on health education and coping. «*It is almost impossible to cope with the changes alone, all the family has to take part and help*», said a nurse when I inquired about the rationale for inviting others. The incorporation of others into the ritual not only breaks the solitude of the ritual subject but also puts the illness in more mundane terms, like who is preparing the food or doing the housework. Thus responsibility and agency are extended to involve those who share his style of living by cooking the food for instance.

By introducing movement, information and social relationships, the medical staff moved Antti from a medical category, needing medical help, to the category of "normal people" again. «*You will be back to normal in three months*», as a nurse said. Medically, Antti's cardiac rite of passage was a success indeed, as the damage his heart sustained was minor, and he was able to go back to work in three months. However, Antti was not just being transferred from being ill to being "normal" again. The purpose of interventions such as preventive education in the reaggregation phase was integration into society with a new awareness of his own responsibilities as a cardiac patient.

The work of liminality

Victor Turner, who further developed Van Gennep's ideas, emphasised that it is the liminal phase that enables the ritual to do the work of transformation. The liminal period is a threshold between states or categories, betwixt-and-between. The ritual subjects in this phase are «ambiguous, for they pass through a cultural realm that has few or none of the attributes of the past or coming state» (1978, p. 249). «Liminars are stripped of status and authority, removed from a social structure maintained and sanctioned through discipline and ordeal.» (*Ibid.*) Having outlined the treatment of AMI as a rite of passage, as a journey through the different spaces in the hospital, outside the previous or coming states or categories, I will now have a closer look at how detachment and distancing of ritual subjects from the established states of political-jural structures enables the process of reflexivity – an essential feature of the liminal period.

There are two processes taking place in hospital liminality. The first of these is decontextualisation; a process in which the sufferer's lived experience becomes objectified and authorised as a problem in the heart muscle with the use of medical technology and knowledge. This object is considered as separate from the patient's personal or social characteristics as we saw earlier in the description of the emergency unit and cardiac care unit. The second process of recontextualisation, taking place in the medical ward, aims at installing medical reification into the context of the patient's lived body and everyday life again, including an effort to reconstruct his subjectivity. These processes (6) overlap with the phases of separation, the limen, and reaggregation in the rite of passage. Here I want to shift from phases or places to the differences between the processes taking place during hospitalisation, and the various reflexivities they enable. In the following extract both these processes are present:

> *«It was time for the doctor's round in the medical ward. The Doctor opened the medical record of Pertti, a man in his sixties, spread the results of the lab tests and ECGs on the bed and took a seat beside the bed. The nurse remained standing at the edge of the bed. The Doctor started to read the medical record: 'So you came on Thursday, chest pain. Smoking as a risk factor, heredity negative, quite a lot of exercise ... There were changes in the ECG as you can see here.' (The Doctor looked at the ECG taken in the emergency unit and drew a circle around the place where these changes could be seen). Then he laid the lab results on top of the ECG and read the results: 'The enzymes have come down, your lipids are a bit high, otherwise it seems to be ok.' Pertti followed all this with his alert eyes. Then the Doctor listened to his chest with a stethoscope.... 'Ok. The damage in your heart is minor. We will go on with the same medication and arrange the cycle test (a test in which the patient's body is stressed in order to see if the heart muscle suffers from lack of oxygen) for tomorrow. If it is ok you can go home ...' Pertti asked the Doctor if stress could have been the reason for his heart attack (he didn't articulate his marital problems as the cause of stress to the Doctor). The Doctor said that of course, it could be related, but there is no scientific evidence for it. 'But if you want to live for more than two years you should give up smoking.'»*

The main focus of the discussion was on medical knowledge of Pertti's body. Information not directly observable by the participants had been gathered during Pertti's hospitalisation. His bodily processes had been visualised by the use of technologies such as the stethoscope, the blood test, ECG, x-rays, etc. These techniques allowed a kind of dissection of his living body, dividing it into its component parts, exposing what life ordinarily conceals (Leder 1992, 22). In the above extract the flowing talk and action in the hospital had already been transformed into a fixed text, a medical record, in which Pertti's story was presented as detached, externalised and objectified. When the Doctor recounted and interpreted the medical facts and showed him the evidence (by drawing the circle on the ECG), he was connecting a process in Pertti's body to the body of universal biomedical knowledge. Although the signs gathered by technological means pointed to Pertti's body, their meaning seemed to come from an authoritative source, the universal involutional realm of scientific medicine interpreted by the Doctor. The medical text constructed Pertti's heart attack as an object, observable through signs, and decontextualised it from his mind and social characteristics.

It is not only the medical text or record that objectifies or structures a certain point of view on reality, but also how it is performed. As described earlier some crucial non-linguistic features like lying still in solitude, detaching the self and social aspects of the person from the problem all dramatically limit the number of standpoints outside the patient's immediate experience on which he could take action. For example, the simple manoeuvres of taking blood tests or x-rays convey the message that the patient cannot be in a dialogic relationship with the realm others control. These tests are taken by nurses who then take them to other people, who remain invisible, to be analysed. The results are then brought to the Doctor who decides what to do according to medical logic. This action takes time and is dispersed in different places while the objectified patient stays still. Objectification is powerful in its ability to define a complete image of reality in ritual contexts – that which is true – that outlives particular instances of its articulation, and which encompasses and subordinates other images (Kuipers 1990, 4-7). External "objective" knowledge obtained by tests and machines constitutes a defining source of "authoritative knowledge", the knowledge which counts, and which forms the basis for decisions made and actions taken (Biesele & Davis – Floyd 1996; Jordan 1997) and structures a view point on the experience. The body is being touched by medicine (7).

The other process, recontextualisation, aims to put the objectified experience back into the context of the self living in social relationships again by scrutinising the everyday life of the sufferer and restructuring his agency. In the above extract, the Doctor took up the possibility of Pertti's return to normal life again. He also tried, after having interpreted the medical facts, to encourage Pertti to change his habit of smoking (which was one of his ways of enjoying life). Pertti's own question about the effects of stress (although ignored by the Doctor) showed that he was actively rethinking his life from the point of view provided by the objectified heart problem. The process of recontextualisation is more explicit in the official nursing ideology of the hospital, which aims at "enabling the patient's growth as a human being". In a more mundane manner nurses speak of "lighting up a spark" in the patient so that he could actively cope with the situation. In the discussions (following the secondary prevention list) on role activities, family relationships, diet, sexual life, alcohol, smoking, keeping fit, etc., information based on epidemiological knowledge of risk factors is related, where possible, to the individual sufferer's particular life circumstances.

The process of recontextualisation differs from the objectification process in three respects. Firstly, it deals with the most mundane everyday activities, and not with abstract biomedical knowledge of one's own body. Knowledge of risk factors is based for the most part on community-level processes and thus has a different relation to the individual from biomedical knowledge, which refers directly to the sufferer's body. The patient has to reorient himself to the most familiar habits of eating and being, as they now become strange and risky. Secondly, control over the situation is transferred from the medical staff back to the patient. Thirdly, spouses and other family members are encouraged to take part. As they are invited to discuss coping and lifestyle changes with the nurse and the patient, the "problem" is extended from the body of the sufferer to include his/her immediate social relationships.

The change from the biomedical focus on bodily processes to the risk factors in mundane activities could be understood as a sign of the plurality of biomedicine, of how biomedicine is not one but many. From the rite-of-passage point of view, it is not the paradigmatic change in medicine which is of interest, however, but moving the suffering body through the various spaces and relationships in the hospital in order to transform it. The ideal is that atherosclerosis in the artery vessel performed by medical interventions (Mol 1988) is integrated with activities in other spheres of life, like having a (healthy) lunch. To effect the transformation into cardiac status the cardiac ritual has to decontextualise and objectify the problem first, and then recontextualise the objectified realm into his life again. Through decontextualisation, a particular experience becomes universalised in terms of medical knowledge and practice and through recontextualisation, the universal becomes particularised again in the ritual context of the hospital. On the societal level, if cardiac care is viewed as a combination of medical and societal efforts to control CHD, these processes are crucial in «creating and re-creating the categories through which men perceive reality – the axioms underlying the structure of society and the laws of natural and moral orders» (Turner 1968, p. 7).

The reflections enabled by the rite for the individual differ in certain respects. The experience of pain and the way it becomes objectified creates reflections on one's body. The patient's physical passivity is often coupled with a sense of not being oneself. «*I'm on my knees* (8)*, I can't tell you anything before I have the results of the test*», as a woman described her situation. Dependent on the use of technology and the word of the Doctor she could not rely on her own bodily knowledge. Many patients talked about the separation between mind and body: «*My mind is recovering but the body is lagging behind*» (or, quite peculiarly, vice versa, the mind is lagging a few steps behind). Biomedicine reshapes the body inside, leaving less room for individual will or choice. It is also experienced as the disappearance of pain, or more existentially as a rescue from death. The recontextualisation on the other hand emphasises the choices of the individual. Although information and practice are based on community-level rationale, the mystery of choice resides in the individual.

Rites of passage and liminality reconsidered

I have applied the concepts of the rite of passage and liminality to demonstrate the processes, which could transform the sufferer's experience during hospitalisation, relying on the metaphor of passage and journey, in which the ritual crossing of a threshold (AMI) means a qualitative change. The argument has been in line with Davis-Floyd's (1992) analysis of modern birth in the United States. Viewing the symbolic elements in the technological procedures of hospital delivery, she argued that these procedures inscribe the values and essential relationships between science, technology, patriarchy, and institutions into the bodies of the birthing women. Encoded in the obstetric procedures are messages that make it explicit that women's bodies are like machines, inherently defective, and should be controlled by technological means. In a similar vein it could be argued that the symbolic elements of medical procedures of the cardiac rite of passage inscribe the cultural messages of a technocratic model of reality and embed it into the everyday lives of the sufferers. The vulnerable body of the sufferer is controllable and transformable by technological means. However, there are some limits in drawing an analogy between birth and AMI on the one hand and analysing the treatment of AMI as a rite of passage on the other.

Quoting Turner, Davis-Floyd (*ibid.*) bases her argument on the transformative power of hospitalisation (as a rite of passage) claiming that «the passivity of neophytes to their instructors, their malleability, which is increased by submission to ordeal, their reduction to a uniform condition, are signs of the process whereby they are ground down to be fashioned anew and endowed with additional powers to cope with their new station in life… Knowledge, or 'gnosis', obtained in the liminal period is felt to change the inmost nature of the neophyte, impressing him, as a seal impresses wax, with the characteristics of his new state. It is not a mere acquisition of knowledge, but a change in being.» (Turner 1979, 238-239.) However, applied to modern hospital contexts, the metaphor of the ritual subject as "mouldable wax" (Turner 1979) exaggerates the ability to convey messages and bring about transformation by the rite of cardiac care. Although "the touch of medicine" impresses the body and changes it, health care officials are acutely aware of how difficult it is to convey information to patients, not to mention changing their being(9).The insight the concept of liminality offers in relation to the cardiac rite of passage is not how the rite transforms the experience in a more or less direct manner, but how the rite posits different standpoints and reflections on the experience. Still relying on Turner, liminality in modern contexts emphasises potentiality and reflection. Liminality is still a phase «in which previous orderings of thought and behaviour are subject to criticism and revision, when hitherto unprecedented modes of ordering relations between ideas and people become possible and desirable» (1978, p. 2). Its power of reflection resides in placing the liminal subjects outside the binding commitments of everyday life. In traditional societies (the concept originated from the study of traditional societies), new modes of thought were presented by showing sacred objects and teaching secret knowledge to the liminal subjects. In modern contexts like a cardiac rite of passage, the 'sacra' revealed to the patients is not secret or sacred in the same way, since all of us are familiar (at least to some extent) with medical technology and knowledge. It has been presented to the patients in a different context, in the office of the general practitioner, TV, newspapers, etc., many times before they enter the cardiac rite of passage. The effect of hospital liminality resides in «cleansing the doors of perception» or «the innocence of the eye» (Turner 1978, p. 11). In the cardiac rite of passage the patients see and reflect on their bodies and everyday lives from a different point of view as the familiar knowledge and practices come to apply to their own bodies and lives.

Apart from the view of the transformation of the liminal subject, applying the notion of the rite of passage in the modern context of a developed division of labour brings up the question of how the subject moves to a new status. By structure Turner means «patterned arrangements of role sets, status sets, and status sets and status sequences consciously recognised and regularly operative in a given society and closely bound up with legal and political norms and sanction» (Turner 1978, 252). Rites of passage are often associated with transitional phases in the human life course, potentially filled with danger. Rites move a person from one status or role to another in the social structure; a child turns into an adult, a childless woman into a mother, a single person into a husband or wife, etc., in a culturally negotiated and controlled way (Grimes 2000). By drawing the analogy with birth further, one can ask in what sense the cardiac rite moves the sufferer into a new status like a woman into a mother. Just as AMI (or any illness) is not directly related to a phase in one's life course, the movement of status depends on the other statuses the sufferer has. All the patients I have introduced have been moved from being healthy (or not having a heart condition) to cardiac patients who are entitled to be taken of care of and to get compensation for medication. Apart from this, their status was recognised differently by the society in relation to their age. Having years of full working capacity ahead, Antti was offered the opportunity to take part in a rehabilitation course. Pertti was retired, so he did not need one; neither did the old lady in the CCU, who would probably have been moved to a institution for the chronically ill if she hadn't died because she was not able to take care of herself anymore. Although focusing on people with a heart problem, there is no clear-cut status into which the rite moves people. The meaning of movement between categories, medical case/social being, healthy/ill, living/dead or having a heart problem/not having a heart problem taking place also depends on one's age and place in society. Antti was taken by surprise when he had his first symptoms:

> «*I was in pain. I sat in the kitchen. My wife said that it's a heart attack. We both laughed. Then she read the description of a heart attack from the medical book. Theoretically, it could be, but on the other hand, it can't… It couldn't be me.*»

It couldn't be him because AMI is something that the old or people living unhealthy lives have. For the older, AMI is more often something characteristic of their age.

The meaning of AMI and its treatment raises the third point to be considered here: how does the description of the structure of the cardiac rite relate to the accounts given by the participants? Viewed from above, the meaning of the cardiac ritual is analysed in terms of what it should do. It often fails to achieve its aims, since the sufferers will not get better, they will not change their behaviour, or they will die. It is not the outcome of the ritual, however, which is of interest here, but how the accounts given by the patients relate to the structure of the cardiac rite and the processes of liminality. In some respects, the accounts of the patients resemble the ethos of the ritual as they speak of «*life coming to a halt*», of the need to change one's way of being: «*I have to slow down and start to think more about myself instead of others.*» Even the echoes of the liminal subject as malleable wax could be heard in the descriptions of vulnerability. Descriptions given by spouses and patients themselves have a similar flavour:

> «*I went to see my husband in the cardiac care unit and felt like I was disturbing him. His eyes were hazy and he seemed to be up to something else.*»

The husband himself described his state later by saying, «*I was not myself then. I could talk all right, but I wasn't there.*» Many patients speak of how they «*got a second chance*» and in the biographical context of having an AMI and going through the treatment have the potential to create a "before" and "after" that differ markedly from each other, as has been well documented in studies of illness narratives using the concept of biographical disruption (Bury 1982; Grimes 2000).

However, a closer look at the various accounts given during hospitalisation shows that thresholds and liminalities can be experienced in different phases. Antti felt that he was in danger during the days before he went to hospital (pp. 8-9). Initially he was not transformed into a medical case by the general practitioner and he tried to go on with his life in spite of his pain. His being at the threshold ended when he was picked out of the queue, «where there were drunkards and everything», taken to the emergency room and given a diagnosis. «*I was so relieved when I saw the text on the ECG: first grade block. At least now they've got something to work on*», his wife explained. For other patients, the transfer from one unit to another is a kind of threshold. Moving from intensive technological monitoring in the CCU to the medical ward may be especially frightening.

> *«The woman in the CCU called us to her bed. She took the nurse by the hand and told her that she is afraid of being moved to the medical ward tomorrow. 'Will they take good care of me?' she asked us. She also made us promise that we would come to see her tomorrow in any case.»*

Another obvious threshold is associated with leaving the hospital. Both patients and their spouses describe how they feel uncertain about themselves. Can they do the right things, like interpreting the symptoms correctly? How much can or should one do during the following months? In what direction is life taking us? So on.

Reconsidering the way in which the cardiac rite moves from one status to another and transforms the malleable ritual subject by the work of liminality, as well as the differences in accounts suggests that as such the concepts of rite of passage and liminality are too general to grasp what is taking place in the treatment of myocardial infarction in a modern hospital. There are three points at which the analyses of hospitalisation as a rite of passage can be complemented by taking a look at the hospital as a modern institution with a specific ceremonial order. These points are the extent to which the liminal subject is being transformed, enabling reflection on the workings of the health care system and one's relationship toward it, and understanding the differences between points of liminality in the structural account and the passage accounts given by the patients.

A ceremonial order perspective

Viewed as an institution, the world of social interaction in a medical encounter can be portrayed as a relatively autonomous realm, structured by rules, rituals and expectations. Inherent in the institutional structures of health care are pre-defined role-identities and the distribution of knowledge that goes with them (Lauritzen & Sachs 1994). Thus, the social ritual in the hospital is based on complex social rules and tacit collaboration between the parties, the fairly stereotyped roles of the medical staff and the patient. The rules involve taken-for-granted rules of relevance and irrelevance and face-saving strategies applied by both parties in the encounter. Each encounter can be seen as a "separate little society" with its own tacit *ceremonial order*, special vocabulary, actions, circumstances, etc. (Strong 1994, pp. 25-37). The rhetorical etiquette, although rarely seen, imposes a grid on everything that is said (or done) during the encounter. In the games of health care encounters, all the players are suited to and know their parts.

Consider the interaction between Pertti and the Doctor (page 11). The encounter followed the expected structure of a Doctor-patient interaction as the Doctor controlled the interaction and flow of information by sticking to medical and scientific facts. Both Pertti and the Doctor played their parts according to expectations (see Parsons 1999). The Doctor had the technical and scientific authority and he passed over Pertti's hint about stress as a cause of his problems as unscientific. He did not want to tackle Pertti's hint any further, as it was something beyond his realm of expertise and irrelevant to the present concern to cure the heart muscle. On the other hand, Pertti saved face by concealing his marital problems behind the concept of stress. (He did discuss his marital problems with the nurse on a different occasion, however.) Both the Doctor and the patient himself portrayed Pertti as a good exerciser with the only exception of «*having a couple of cigars now and then.*»

Following Phil Strong (1994), this piece of interaction could be described as a bureaucratic form of ceremonial order (10) in which the medical staff as a collective is granted massive but anonymous medical expertise. In the bureaucratic form of ceremonial order, the patient is typically passive and granted little overt technical authority. The moral work in this kind of ceremonial order invokes an idealised world in which the patient is a free human being, responsible for his actions. Pertti granted technical authority to the Doctor and trusted the medical interpretation and treatment of his condition: after all, he had been given "a second chance" by its success. He accepted the view offered by the Doctor that he is responsible for his future actions. Pertti also explicitly expressed his morality as a reasonable man by showing his willingness to adhere to the doctor's advice on giving up smoking.

Firstly, in relation to the rite of passage perspective, the emphasis here is thus more on maintaining the status quo than on transforming a liminal subject (Turner 1992), as the game of the encounter depends on some prior legislation or social rules with emphasis on sustaining these rules. Instead of describing Pertti's transformation as he is being moved through the different wards, the image of a patient engaging in face-saving strategies in a bureaucratic form of ceremonial order is being portrayed. By adhering to the rules and roles of the given ceremonial order and managing his expressions about himself, Pertti ceased to be a «*tabula rasa*» (Morris 1986, p. 255) on which the ritual messages could be inscribed. Liminality as anti-structure is filled with roles and statuses, not outside them.

Having said that, I have to add that to portray the image of patients engaging in a series of ceremonial orders during hospitalisation, with no overt intention to transform them, is also a simplification. In this regard, the doctor's warning that Pertti would die in two years if he did not stop smoking is revealing. According to the etiquette of the hospital, he was being too strict and normative since one should not make exact prognoses nor coerce or threaten the patients. The grid of the ceremonial etiquette, although providing the medical staff with medical and technological authority, also imposes limits on how to transform patients viewed as free agents who decide for them. The staff often felt frustrated because of their inadequate means of effecting changes in the habits of the patients:

> «*They'll promise anything here, but as soon as they get home they get back to the same old ways of doing things… After all it is up them*» (a nurse in the medical ward).

The remark made by the Doctor intertwined the transformative ethos and the grid of the ceremonial order. The ceremonial order provided him with the power to comment on Pertti's smoking, but by breaking the order with a threat, he tried to overcome the limits that the grid imposes on moulding the life of the patient.

Secondly, the theme of one's relationship with the health care system or the state was also present in the story of Pertti and his smoking. By pointing out a defect in Pertti's behaviour, the Doctor made a moral claim about Pertti's own part in his heart attack. Although the heart attack as a physiological process was something he could not handle by himself, he was at least partly responsible for its occurrence. The moral was that the doctors and society would cure him but he, as an independent person, should play his own part by avoiding risk. The moral claims made by the health-care system are closely related to and overlap with the reflections on one's everyday life already described, the difference being that while the latter is embedded in everyday contexts, the focus of the former is on the relationship between the sufferer and the "system". Paradoxically for Pertti, the doctor's advice signalled that the staff were concerned and did their job well instead of being mere advocates of a cold and distant bureaucratic system. I believe that Pertti's observation that «*the staff here are a different race (considering and caring)*» gave him the moral strength to play his part in controlling the situation well.

Antti (see p. 8-9) provides a different example of reflection. He too adhered to the ceremonial order of the hospital, reached a working consensus with the staff, and engaged in the overt function of curing the sick, the disciplined and routinised activity of the hospital, by playing the roles the institution offered him. However, he felt that some degree of categorisation was being imposed on him and tried to avoid it.

> «Antti was invited to the physiotherapist's room to learn about exercise. An older woman with a walking frame and a retired man accompanied him. First, they were shown a video on physical rehabilitation. All three made remarks on the main character on the video, a young and healthy-looking man to whom everything from moving around to changing his lifestyle seemed to be easy. The physiotherapist, a young, fresh-looking woman, continued by asking questions about their lives and giving advice on exercise. Apart from answering the questions, Antti kept quiet for the most part, while the other man made jokes about going on as usual, having barbecues and drinking cognac from a pint glass. The therapist also handed out a paper with contact information on the local society for heart patients. The older woman was overtly grateful, but both men refused to take the paper as they didn't need it… Later Antti told me that they (the staff) take advantage of the position of the patient by offering material when the patients are vulnerable and least able to resist. In contrast to the older lady, who seemed desperate to grasp any information, Antti was strong enough to say no.»

While Pertti was willing to adopt the idea of restructuring his life in relation to his heart problem, Antti actively resisted the pure imprint of paradigmatic structure:

> «*They were imposing the identity of a cardiac patient on me. I don't get it. How would a heart attack make me similar to other people who've had them? This can't provide a basis for interaction with other people.*» (11)

He refused to take part in a rehabilitation course offered to him. Although adhering to the etiquette, putting the technical authority into the hands of the medical staff, listening to what they had to say, and feeling that he was taken good care of, he was able to maintain a distance from the messages communicated to him, especially the imposition of a cardiac identity. He did not accept the moral claims on his life and personality made by the staff. On one occasion, when Antti expressed his willingness to have an Angiography in order to have a more exact diagnosis, this overt working consensus was broken.

> «Antti was ready to go home. The Doctor came to give him the prescriptions for medication. She said that there were no signs of ischaemia in the exercise

> test. 'Later (after 3 months) you'll have to come here for an x-ray, an ECG, in the lab, and to see me.' Antti replied that he was going to have an Angiography in three weeks' time. The Doctor was taken by surprise: 'Why? Because of the symptoms on the 3rd of May?' Antti explained that he had made an appointment with a private clinic. 'But there are no signs of ischaemia', the Doctor replied (a little irritated). 'But you can't be absolutely sure on the basis of the exercise test, can you?' Antti asked. 'No you can't', the Doctor admits, 'but there is no point in doing an invasive examination, it is risky'. 'I want to optimise, I want to know in case of another attack', Antti made his point. They went on discussing the possibility and impossibility of being prepared for another heart attack by technological means. The Doctor concluded by saying that it was up to Antti to choose to have an Angiography, but it could not be financed by the state.»

At one level, the disagreement was about the adequate level of technical visualisation and control over his body. Antti wanted a more technical approach instead of rehabilitation *«emphasising psychological and lifestyle adjustments»*. Using concepts introduced earlier, the focus was on objectifying his problem further. At another level, the role of society was brought into focus. When talking to the anthropologists, Antti was not critical of the physiotherapist or the Doctor he had engaged with, but criticised the welfare system as a whole for spending money on rehabilitation "nonsense" and not enough on technological care. Here too the responsibilities of the state to take care of the sick were discussed. The choices of the Doctor, who had to follow the standards of the cardiac chain of care, were restricted and Antti's criticism placed both the medical staff and himself in the same situation, within the grid of the system.

Thirdly, the ceremonial order bridges the discrepancy between the structural description of the treatment of AMI as a rite of passage and the accounts of passage given by the patients. As stated earlier, patients often experience thresholds while they are being transferred from one ward to another, or on entering or leaving the hospital. Antti felt he was safe when he was finally admitted to the emergency unit and was diagnosed. While he gave up his agency, he felt comfortable surrounded by the technology and following the hospital routines. The routines developed in the hospital, the formal and conventional actions, brief rituals between persons, have a Janus face: on one hand they are just strategies which enable a working consensus while on the other the etiquette of interaction is embedded with morality and sacredness (Heiskala 2000). Although frightened of his state, Antti's anxiety was at least partly relieved by the technological routines taking place in the emergency unit, which reassured him that actions were being taken to cure him. Experiencing transfers from one unit to another as thresholds suggests that hospital liminality consist of islands of order. The rules and aims of each unit or ward transform the unit's raw material everyday life into distinct, ordered and meaningful occasions (Strong 1994, p. 23).

The cases of Antti and Pertti illuminate how the general view on transformation intertwines with a more static ethos of the institutionalised encounters. By knowing how to actively play their part in the institutional games, they maintained the status quo of the hospital. At the same time, however, the hospitalisation transformed their way of perceiving their situation. The treatment marked their lives differently as Pertti was ready to follow the logic of recontextualisation while Antti wanted to follow the path of decontextualisation. Thus, the work of liminality resulted in two different ways of reflecting on the situation rather then reshaping the malleable subjects in a straightforward manner. The way they accepted or rejected the moral claims made by the staff suggests this too.

Concluding remarks

Stemming from different conceptual frameworks, the use of the concepts of the rite of passage, liminality, and ceremonial highlight different aspects of the treatment of acute myocardial infarction in a modern Finnish public hospital. On the one hand, the rite of passage and liminality emphasise the transformative quality of the patient's journey through the wards of the hospital. The notion of a ritual passage has the advantage of examining the structure of treatment as a way to move individuals to a new social category. The ritual passage aims to transform the sufferer and the destiny of his body by technical means as well as by creating an awareness of his own responsibility. The same themes taking place in the treatment of individual sufferers are present in the combat against CHD at the societal level. The cardiac chain of care as a whole aims to transform the nation into a healthier one by reducing the incidence of CHD by technological means as well as by creating citizens responsible for their own well-being by educational means.

On the other hand, the ceremonial order perspective stresses the importance of predefined roles and sustaining the status quo in the face-to-face institutional encounters. A bureaucratic organisation aims to sustain its own logic of conduct rather than to transform the ritual subjects. The ceremonial order perspective complements the generality of the passage point of view by filling the anti-structure of liminality with the rules and morals of the institutional etiquette. Rituals can fail in their didactic and socialising purposes as some patients can maintain a distance between themselves and the ritual model.

The transformative and ceremonial aspects intertwine in the reality of cardiac care, complementing each other's weaknesses. The ritual passage notion shows how the routines and rules of the ceremonial order become meaningful and moral. The encounters, with their various diagnostic, curative, and informative tasks in different phases of hospitalisation, together form a passage through which the patient "flows". Even one encounter may have elements of sustaining the ceremonial order as well as transformation at the same time. However, the passage consists of distinct, ordered and meaningful occasions rather than an unstructured state during which the essential messages, technological control and responsibility for one's health are inscribed directly into the bodies and lives of the ritual subjects. It is useful to look at the different kinds of reflections the ritual passage and the ceremonial order evoke in the individual in order to get a fuller picture of how the experience is constructed and transformed during hospitalisation. The reflections on the body, lifestyle, and morals in the context of the system acquire a different weight in each sufferer's idiosynchcronic account of AMI and its treatment.

Notes

(1) The topic of my research is men's and women's experiences of coronary heart disease. The main aim of the study is to see how different meanings are bestowed on CHD in Finnish contexts. Special emphasis is put on how the lived experience of suffering is decontextualised and objectified by local biomedicine, and how the objectified problem becomes recontextualised again into everyday contexts, where the competing demands of the society and the body are met. Data presented here is based on my fieldwork in a local hospital in southern Finland from 1.10.1999 to 31.5.2000. For six months I did participant observation as a nurse's apprentice in the emergency unit, cardiac care unit and the medical ward. I have interviewed patients and medical staff in the hospital (n = 30). I have also taken part in the activities of a local group for cardiac patients and interviewed sufferers in their homes.

(2) Medically, coronary heart disease means a lack of oxygen in the heart muscle due to atherosclerosis. The main symptom is severe pain in the chest. If one or more of the vessels get blocked (acute myocardial infarction), part of the heart muscle is damaged. The main risk factors in developing symptomatic atheroscleoris are high blood pressure, smoking, fatty food and lack of exercise.

(3) 13,000 deaths in 1997. Morbity and mortality from CHD reached its peak in the 1960s (being the highest in Europe) after which there has been a 50% decline in mortality (from age-standardized mortality of 500 among middle-aged men to 200 in 1992) due to advances in reducing the known risk factors and improving the treatment of symptomic CHD. In spite of decreases in morbidity and mortality, the number of people suffering from CHD is still increasing as the population gets older.

(4) As in other Nordic countries, the Finnish welfare legislation quaranteed equal care for every citizen according to the idea of universalism. The welfare system is based on government budgets.

In the 1990s cuts in the health care expenditure (10 percent in real terms in the early years of 1990s. In 1999 Finland's total health care expenditure equalled 6.7 percent of GDP) were introduced, resulting in a public discussion about prioritising conditions under public responsibility as well as an emphasis on individual's responsibilities.

(5) This choice of focus has its advances and limitations. In the hospital the technical control, health education, as well as the sufferer's relationship to the health care system are taken to an extreme. The power of medicine to save lives as well the theme of using power in everyday life are both present here. I will also focus on people having their first heart attacks in order to emphasise the possible transformations taking place. The bias toward acute cases closes off aspects of the cardiac chain of care such as general practice, as well as those sufferers whose condition has become chronic.

(6) Kohn (2000) outlines a similar process of universalising and personalising in the medical management of children with facial disfigurements by using the concept of therapeutic emplotment (Mattingly 1994).

(7) Alan Radley's (1996) concept of 'non-experience' suggests the paradoxical effect of bypass surgery which has the power to bring together the patient's body, self and biography, although in the operation itself he/she is actually unconscious. Here passivity and leaving a pure imprint or mark of medicine's paradigmatic structure on the lives and bodies of the sufferer is taken to its extreme.

(8) "Olen rähmälläni" in Finnish.

(9) Davis-Floyd notes that the ability to transmit the technocratic message or mark the body by biomedicine also depends on the prior views and attitudes the liminal patients have. Mothers with positive views on medicine accepted the technological birth more readily than mothers with negative experiences of medicine.

(10) According to Phil Strong (1994) the ceremonial order (or the role expectations) of the clinic has two key variables: the amount and type of technical authority claimed by the participants, and the overt types of moral work that actors are engaged in with respect to other participants. The bureaucratic form of ceremonial order differs from aristocratic, private and charity forms of etiquette, each of which has its own division of technical and moral labour.

(11) Antti maintained a distance from other patients as well. "The three men in my room were telling their stories over and over again. I didn't see the point of telling mine." Other patients have reported how the atmosphere between the patients is exceecptional, "as if the threat of death united us somehow."

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 311-331

Magic and ritual in mad stories

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Lisa, a fragile Indonesian woman, was walking along the paths of Saint Anthony's park. Saint Anthony is a mental hospital. Lisa was dressed in red, yellow and blue. She looked like a painting of Mondriaan, the colours of which could cheer someone up on a grey Dutch day. She had put on all her clothes and she carried the rest of her belongings in a grey garbage bag. She looked like she was being hunted and mumbled formulas to avert evil or the devils. I could not understand her words, but she repeated them as her garbage bag rustled over the pebbles of the path. When she arrived at an intersection of two paths where low rose hips were blossoming, she stopped and went into the bushes. She lifted all her skirts and urinated. She stood like a colourful flower amidst the green of the bushes and stared into the sky. A passer-by from the village where Saint Anthony's is located would probably have pretended not to see her, knowing that Lisa was one of the "chronic mental patients" of the wards. Or urinating so openly in the park may be experienced as a 'situational impropriety', but as many villagers told me: «They do odd things, but they cannot help it.» The passer-by would not have known that Lisa was a "walking story", that she had ritualised her walks in order to control the powers that lie beyond her control. Lisa had the diagnosis "schizophrenia" and she suffers from delusions. When she has acute psychosis, she needs medication to relieve her anxiousness. Her personal story is considered as a symptom of her illness. That is, in short the story of the psychiatrists of the mental hospital. Her own story is different. Lisa is the queen of the Indies and she has to have offspring to ensure that her dynasty will be preserved. On that day she believed that she was pregnant and that the magicians would come and take away her unborn baby with a needle. To prevent the abortion, she had to take refuge in the park and carry all her belongings with her. However, queens also have to heed nature's call and thus she went to the best place she could find: the rose hips.

Mad stories are evocative and metaphoric, but one does not understand exactly what is going on in them. They are full of symbols, but many people think that these symbols are used in a very personal way. They are often considered as incoherent and incomprehensible. Some authors have described mad stories as “ununderstandable”. For example, Jaspers (1974) argues that although people with schizophrenia are diverse, they all have the following in common: they are strange, they are enigmatic, they are alien, and they are bizarre. They are unknowable. You cannot empathise with them. Their symptoms lie beyond the realm of human meaning, beyond the possibility of human interpretation. They are, not to put too fine a point on it; “ununderstandable” (quoted in Barrett 1998: 469).

There is a vast number psychological and psychiatric studies that have described the abnormalities of speech, behaviour, signification, interpretation, metaphorisation or reality testing of schizophrenic people. Their stories escape every classification, save that of “psychotic stories” or “crazy stories”. However, as psychotic stories they are quite traditional. The basic elements of content and form have changed little over the centuries and their underlying structure does not vary across cultures (Perry 1976; Devereux 1980; Foucault 1961). Other authors have described the stories as those that cross social and cultural boundaries (Foucault 1961; Goffman 1961). However, with a few exceptions (e.g. Obeyesekere 1991) those studies have not led to thorough research of the relationship between culture and personal worlds. Schizophrenia is a well-documented illness and considered «a serious mental disorder of unknown cause characterised by delusions, hallucinations, associations of unrelated ideas, social withdrawal, and lack of emotional responsiveness and motivation» (Kleinman 1988: 34). It is increasingly assumed that schizophrenia has a pathological basis, that it is a brain disease. The consequence is that the focus is less on stories of schizophrenic people and more on refinement of diagnoses. This leaves little space for the study of the stories as the locus of the work of and with culture.

In this paper, I do not aim to understand madness – or schizophrenia. I will try to understand culture through madness, more specifically through mad stories. I will argue that the stories are rituals to control powers of madness and the health system that lie beyond the control of people. I will focus on the stories of chronic schizophrenic people, who live in Saint Anthony’s, a mental hospital in the Netherlands.

Symptoms or symbols?

Psychiatry has kidnapped the stories of mad people. This means that they are transformed and re-interpreted into “medical stories”; they become pathographies. The greater part of scientific research on schizophrenia is blind to the meanings of the illness in the lives of the individuals. What the medical world sees as a disease has little to do with what people experience. Yet, psychiatry has an interest in mad stories. In the latest version of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM IV) the importance of stories is stressed for providing the diagnostician with a better understanding of the cultural background and the explanations of the patients. Although cultural concerns are represented in a significant way in the text of the DSM-IV, members of the culture and diagnosis task force heavily criticised the text. Good (1996) discusses the critics: the text makes too sharp a distinction between disease and illness, wherein disease is viewed as a universal biological entity, while illness consists of forms of experience and cultural interpretations of the individual and cultural groups; particular forms of science are hegemonic and there is a «reluctance to incorporate knowledge generated at the social margins», which means «symbolic violence» (Good 1996: 129-130). Diagnosis means that the story of schizophrenic people (and others as well; let us say the original story of an intense psychosis) is incorporated into a psychiatric myth and acquires the meaning of a *symptom* of schizophrenia. However, Littlewood and Lipsedge say that it is «particularly difficult to decide whether a person’s belief is a delusion or not relative to the usual beliefs in his community when its culture is changing or when it contains a variety of conflicting belief systems» (Littlewood & Lipsedge 1989: 207). The authors give many examples, which show that, under certain circumstances, unusual beliefs are accepted or explicable. They argue that the community can use the stories of psychotic people as metaphors for their own experiences. The author argues that mad people do not become sane when others tolerate and accept their stories. I agree, but I would like to stress that the view that mad stories may be a metaphor for the experiences in a community is surely an attractive one. This view is also reflected in the argument that mental illness is a myth (Szasz 1987), and in the comparison of madness with art (Laing 1967) or modern society (Sass 1992). Madness and its stories become *symbols*. However, Barrett writes – and I substantively agree – that the problem with the idea of the relationship between madness and art, or between madness and modern society, is that these views may lead to re-stigmatising schizophrenic people because they will represent symbolically much of what is going wrong in societies (Barrett

1998: 488), while they also have to deal with the pain and suffering of severe illness. This does not mean that the stories of mad people are mere symptoms and not symbolic. Mad stories rest on core models, myths and metaphors of a culture. For example, Perry (1976) found that there were common themes and personalities – i.e. the hero, the victim, God, the queen or the king – that serve as symbols to signify an inner journey and a process of renewal. These symbols are used to make sense of lives and suffering. They also expose the building blocks of culture by reaffirming and reinforcing them.

The problem with mad stories is that they are considered as alien. The symbols used are personal/idiosyncratic. The distinction between personal symbols and public symbols seems of importance in the stories of schizophrenic people. It is generally assumed that the use of symbols in mad stories is personal, if not idiosyncratic. Devereux (1979) defines a symbol as a special form of fantasy, «which as a rule, stands for something having, or alleged to have, an existence, and susceptible of being designated by a conventional and specific signifier» (p. 19). Convention is an important aspect of public symbols. Devereux tackles and questions the problem of the difference between private and public symbols. He concludes that the nature and genesis of private symbols does not differ from that of public symbols, and that both can be decoded by recourse to identical methods and techniques. Obeyesekere (1991) also discusses the distinction between private and public symbols. For this author, the level of the symbol (public) can be reverted to the level of the symptom when a person repeats his or her acts compulsively. The author argues that a symptom is characterised by an overdetermination of motive, while a symbol is characterised by a surplus of meaning. The difference between a psychotic person and for example a priestess would be that the psychotic person moves in regressive direction as he acts out the symbol system, whereas the priestess does the reverse (Obeyesekere 1991: 14). The significance of this distinction is that people express their ontological problems of existence and being through the available cultural repertoires. Personal symbols are cultural symbols; they are public and private at the same time. Obeyesekere sees the distinction between personal and public symbols as a false distinction (1991: 24). I argue that one may view the stories as «a combat zone of power and definitions» (Taussig 1980: 9), a combat in the social arena between culturally constituted meanings and forces that shape the context of the daily lives of mad people, on the one hand, and the lives, emotions and experiences of mad people on the other hand. The basic problem in the combat is that symbols, like culture in general, are fickle and prone to different meanings; they are characterised by ambiguity and can be manipulated.

Besides, when people are overwhelmed by intense experiences (like psychoses), it is difficult to find an acceptable code to communicate. Littlewood and Lipsedge write: «It is difficult to explain the overwhelming hold symbols possess over us unless they were learnt in association with powerful personal experiences… they [the symbols] appear both to have a personal emotional or sensory pole and also articulate general culture and social concerns» (1989: 220-224).

However, the stories of my research are often not the stories of overwhelming psychotic experiences. They are "chronic stories", what Obeyesekere would call "compulsive repetition". I was able to follow people for many years and to read in their files about the kind of stories they had before I started my fieldwork. It appeared that the stories had remained very similar for several decades. They had never changed. They have gained the character of liturgical formulas.

To call those stories "compulsive repetition" does not explain why they are compulsive. It is assumed that schizophrenic people lack the capacity «to locate the self as actor within a seamless unity of past, present and future» (Adam 1992: 159). Mad people are believed to mix the past and the future without being able to construct a reality in the present. It is not clear to what extent the chronic use of drugs contributes to the chronicity of schizophrenia. The side-effects of long term treatment – tardive dyskinesia, feelings of emptiness, feelings of being "cut off" from the world and other sensations – may mean that people cannot act in a creative way and may withdraw from the social stage (cf. Warner 1985). However, more research is needed in order to gain a better understanding of the effects of this drug use. It is true that the stories point to a «frozen liminal state» of mad people, as Barrett writes (Barrett 1998: 481). According to this author, it is because rites of aggregation are vestigial or absent all together. Others, like Estroff (1993), have argued that society is very sceptical about chronically ill people. Society cannot tolerate large numbers of chronic mentally ill people, but it cannot neglect them, Estroff continues. The problem is that suspicion may increase about the unwillingness to get well. This can be illustrated by one of the many events I observed at the garage near Saint Anthony's. In the morning when the mechanics in the garage were working hard to get all the cars fixed, patients would come and hang around in the doorways with a bottle of beer in their hands, saying: «You are crazy! You have to work to drink a beer! I don't! I get my money and I am free.» The tolerance and understanding of the mechanics eventually would eventually be ground down because the patients touched a sore spot. The 'frozen liminal state' or chronicity of schizophrenia may also be explained by factors like the growing numbers of mental health professionals and the demand for jobs, the widespread belief that these people need medical care, and income maintenance resources that are illness-tested and bound to deservedness through disability (Estroff 1993: 251).

The explanations given for the chronicity of madness only partly explain why mad people use their special ritualised stories. This question can be answered to some extent by the work of Goffman (1961), who showed that the behaviour of mad people might have no sense for those who live outside a mental hospital, but that it is meaningful for those who live within. Goffman showed that the odd behaviour of patients was often a sign of sensitivity to social rules and norms. Through breaking the rules, patients showed their awareness of them and how the rules worked. Corin (1990) showed that the behaviour of schizophrenic people was based on cultural norms and values and that, for example, 'withdrawal' – which she called 'positive withdrawal' – made sense in the context of a life in the context. Both studies did not explain why the behaviour (and the patients' explanations) remained the same over time. The 'sameness' in time and the formulaic nature of the stories, and the fact that the stories which were told in Saint Anthony's often became flesh and blood (i.e. were acted out or performed) became a topic of my interest. I decided to do away with the traditional way of approaching mad stories and to presuppose that the stories (and the subsequent performance) were magical means.

Mad stories, magic and liturgy

In madness, extra-ordinary forces drive people away from their community and themselves. Mad people try to get grip on their lives and to influence its course, which actually lies beyond their control. They do so through myths and symbols, which they use as magic.

Usually, magic is understood as something by which people influence the supernatural powers in the world. Traditionally, anthropology approaches magic in relation to religion. However, the concept may be used in a broader sense without referring to religion directly. In this sense, magic is a form of human control over something – in the perception of people – that lies beyond control or over which individuals have little control. In madness, ghosts, devils, voices from heaven and spirits of the dead haunt people and these are controlled by specialists. In this context, it is meaningful that psychiatry is sometimes seen as the "new religion" of modern societies. It has means to control and manipulate the powers of madness through the rituals of therapy and the use of medicines. However, chronic schizophrenic people are difficult to control. Patients of Saint Anthony's know for example very well how to escape regimens or how to play with rules and how to influence the flux of daily life in the wards.

The idea that certain phenomena in modern societies are very similar to those that take place in bodies during magical ceremonies is described by Gil (1985), who sees the study of forces as the way to understand how signs and symbols function in their own right, sometimes in a way that may differ from the way that is usually attached to them. The latter is what happens in stories of chronic schizophrenic people who also try to control the powers of madness. Magic is the ability of words to affect things. In a *«jeu des ressemblances»* signs, symbols and myths are recycled, mixed, and put together in a way that alienates others, but which has the power to manipulate the course of events and the others' responsive actions. This was exactly what nurses in the closed wards of Saint Anthony's always complained about; their plans were thwarted by the incarnate stories of their patients; they felt manipulated, and the daily routine was disturbed. However, the magic of psychiatry has more prestige than that of schizophrenic people, and because it has, there is a gap between the two and the stories of mad people will no longer relate to those of psychiatry.

It is tempting and reasonable to describe the world of chronic schizophrenic-psychotic people as magical if one looks at core aspects of the affliction: "reality testing" and the differentiation between logical and pre-logical thinking. Generally, it is assumed that schizophrenic people live "outside reality". It is also suggested that the psychotic world is irrational. However, it can be misleading to contrast the world of normal and abnormal, reality and "outside reality". First, schizophrenic people also live in "reality" (the normal) for most of the time. Second, the magical world cannot be described in terms of the normal discourse. The mad world has its own universe of discourse, its own conception of reality and criteria of rationality, perhaps different from the non-psychotic world. Up to here, the argument is similar to Winch's, which describes the scientific form and the magic-religious form of thinking as a distinct form of social life whose practices and beliefs are only intelligible in the context in which they are held (Winch 1958). This is precisely the argument of Goffman (1961) that I have described in the previous section of this paper. It is also true, but not suprisingly, that the psychotic world is often seen as "savage", that psychotic people are, to put it in Comte's not too fine words, «slaves of the infinite variety of phenomena' and 'nebulous symbolisation» (Comte 1908, cited in Lévi-Strauss 1996). However, Winch insisted on the incommensurability of the two worlds (scientific and magic). This would mean that no communication is possible. As we have seen in the discussion on private and public symbols, the symbols used by mad people are known, public and private at the same time. The differences between the two worlds lie in the fact that non-schizophrenic people and chronic schizophrenic people live different forms of life. For this reason, the magic world of mad people demands its own discourse, logic and rationality.

There is another fascinating parallel between the magic world of mad people and other magic worlds: power. Both, Taussig (1987) and Lévi-Strauss (1955) discussed the magical power of the written word. To quote Taussig (1987: 262): «what is in effect obtained through the purchase of magic books is the *magic of the printed word* (my italics) as print has acquired this power in the exercise of colonial domination with its fetishization of print, as in the Bible and the law. *Magica*, so it seems to me, does not so much magicalize colonising print as draw out the magic inherent in its rationality and monologic function in domination.» I see that the magical books of the Colombian Indians parallel mad stories in the idea of the power of written words. Schizophrenic people are also very aware of the power of reports, files, judicial decisions, etc. – all written words that determine and control their lives. The patients often counter them with letters to the board of the hospital, psychiatrists, judges, or other personnel of Saint Anthony's; repeatedly and in a ritualistic way, often with similar words. Lévi-Strauss (1955) described the case of chief Nambikwara, who imitated ethnographic writing and in so doing gained prestige among his people. This example also shows a similarity with the patients' writings. For example, Rosemary, an older schizophrenic woman in one of Saint Anthony's wards, had a typewriter in her room on which she wrote letters about her life to staff members, to me, and to her mother. The typewriter gave her prestige in the ward; her room partly gave the impression of an office (she was a secretary in one of the Dutch multinationals), or a "writer's room". Besides, Rosemary tried to convince others with her letters that she, although "mad", was capable of controlling her own life. Rosemary repeated her typewriting and her stories over and over again. It seemed, like the stories of other patients, a ritual performed with symbols, words, and attributes.

The repetitive and formulaic nature of mad stories resembles the fixed rites in a liturgy, although this "liturgy" is not like the religious liturgy, for example, in that it does not serve the community. However, mad stories have important liturgical characteristics in their repetition of the same symbols, words, and actions. Besides, like in a liturgy, they need answers from others (staff members). Mostly, it is assumed that the stories are about the past; the events of the past are constructed within the personal and social history of the patients. Thus seen, the stories are attempts to give meanings to the past. This is also the case in liturgy: what happened in the past – for example, the Last Supper – is re-given meaning and memorised. However, mad stories are not so much attempts to remember the past or to give meaning to it; they are attempts to master and control the future. This also resembles the liturgy; it means people (and gods) gathering and renewing the bonds within the group. Mad stories reclaim the place of their tellers in the community.

Having written all this, I will describe a case in which magic and ritual play a prominent role and illustrate my arguments.

Big mother is watching me; the magic world of mother and daughter

Rosa's story and life is full of magic performed mainly by her, her mother and sometimes by staff members of Saint Anthony's. Her mother is the magician who caused the illness in her brains. Rosa told me what her mother did:

> *«My mother is an insane clairvoyant. She can tease people, gives them needs and takes them away. She will let something come up from her stomach and this substance I inhale.»*

This narrative sounds odd when one does not know the context. Rosa comes from a farmer's family. When her father died Rosa and her mother remained together. The brother succeeded his father as a farmer and Rosa and her mother left the farm and went to live in a nearby city. Rosa was three years old when they left the farm. Rosa and her mother had a symbiotic relationship, which became in the course of the years a *folie à deux*. Her mother believed that a magician was trying to get into the house in the city, into the bodies of herself and Rosa. The magician was evil, a black sorcerer; he threatened them both with misfortune and disaster. The mother practised magic to chase away the magician who was continuously lurking behind the garden bushes. The mother's magic was performed to protect Rosa from the magician. She kept Rosa in the house and injected her with all kinds of vitamins, medicines and psycho pharmaceuticals that she bought (often illegally) in Belgium. Rosa did not believe totally in the magician and she resisted her mother. She wanted to live her own life, to have boyfriends and to go out. Her mother had a brilliant career in mind for her daughter. She repeatedly stressed that they "belonged to the elite"; they were "rich" and "owned a lot of land", which was sold when they left the farm. However, when Rosa wanted to do something, like making friends, her mother came up with the magician, who would surely do evil to her. Rosa made great efforts to escape this double bind and her resistance led to fights between mother and daughter. They broke furniture, windows and doors and after some years, their neighbours started to complain about the noise and the screaming. They reported them to the police, who took Rosa to the mental hospital, because she was aggressive and psychotic at that time. This intervention occurred several times and after years of terror and revolt, Rosa was permanently admitted to Saint Anthony's. Rosa's mother moved to Belgium, where she bought a flat. When Rosa lived in the hospital, her mother could not leave her in peace. She wanted to take Rosa to Belgium, because – she said – in a Belgium hospital Rosa would be "really locked up". The mother kept writing and complaining to the hospital and to the court that made the decision to admit Rosa. She forced Rosa to write too and would add her comments to the letter. I quote two of her comments:

> *«One can see in this writing (the letter of Rosa to the Hospital's board) that she does not belong in this hospital, my daughter Rosa. The magician should be treated. That should be a relief for society. My daughter did not ask for any treatment.*
>
> *It would be better if this killing magician were taken away, or if one does not want to risk anything, shoot him [...] I hope the healers and other experts will join us!»*

When Rosa and I talked about her life, she had lived for over twenty-eight years under the terror of her mother's magician. How did she experience this horror and what did she think the consequences were?

> *«I am very sick in my head. I am totally at odds with my head. Many spirits live in my head. When I get killed, I will not return in my body. The spirits do this to me. I am locked in my head. My head is I. The roof of my head is I. And I am sick in my head. Maybe it is the gland that is I. I would like to scream and I always wanted to be dead in my head. It is too late now. I will kill myself. My educators made a kind of Christ of me ...»*

People sometimes say that they will have "to get something into their head". If this old saying has some truth, this is exactly what happened to Rosa; her mother got the magician into her head. For Rosa, the magician is an evildoer who made her mad and took her life away. This magician did not lurk in the garden; she was inside; her mother who could foresee every movement Rosa made, even when she lived in Belgium. The mother put evil things into Rosa's head, absurd feelings, aggression, the wish and the fear to be killed. Rosa said:

> *«We were in our living room and my mother was there with Doctor Oliver and me. My mother called the bad magician Henry and the good magician Mark. That magician could change colours and smells and then the Doctor said: 'If he can do*

> *that, he is very real.' My mother said: 'Yes, he can do that ...' I don't know if they were in the house. Maybe my mother was thinking of me, that I was the bad magician, Henry, the bad magician. I didn't know those magicians, then I let my thoughts go free and I met people, like Mister O'Hara's nephew. He is a farmer and I thought: 'He is Mark, the good magician ...' I thought that there were bad people. My mother made me believe in bad people. However, I have to look for myself and then I know that not all people are bad. Nevertheless, if I want to stab G. (a patient), I'm bad ... I am afraid of those desires ... Creepy thoughts ... I was in love with Doctor Penn, my mother was also in love with Doctor Penn, then, then there were feelings, and I stabbed my mother with the scissors in her hand. I had to get rid of my feelings ... My mother is an insane magician.*
>
> *I'm in an asylum now, because I had a fight with my mother. She poisons me and gives me sexual feelings. My mother is a bore; she wants to wash my brains ...»*

The mother spins a web of imagination, magic, threats, prohibitions and stories around her daughter. She practises her magic – to counter that of the magician – by needles and pills that have a force to protect Rosa against the evildoer. When Rosa was in the emergency clinic, the nurses discovered serious haematomas on her arms and thighs, the result of amateur injecting. To make it even more realistic, her mother called the general practitioner. The physician knew who was mad, but he was relatively powerless to get the mother into psychiatric treatment, because she refused. Thus, Rosa was admitted. She felt herself a sacrifice, strangled in a web of magic and powerlessness:

> *«My educators made a kind of Christ figure of me. Abraham also wanted to sacrifice his son, but God didn't allow it. I saw a movie about black people and they threw the most beautiful women in the sea and called the sharks by means of shells ...»*
>
> *«People think that I should be killed. I am a sacrifice. I am a sacrifice. People think I should die. [...] When I slept with my mother, there were boys standing beside the bed and my mother and my brother killed them, they were killed. I believe they fell in a wringer; they were crushed or fell into a volcano. I believe, they will kill me by heating a screwdriver and putting it in my navel.»*

The mother seemed to have unlimited power over Rosa. She was omnipotent and her black magic was directed to Rosa's destruction and death. I quote one of the letters that Rosa wrote to me about her mother:

> *«Long ago I went with my mother on vacation to Spain. I bought a toy: a donkey. I beat my mother on her head with a shoe. I stabbed my mother's hand with a file. We had money, but I never had it. I live on social security. Now I am in an institution, because I had a fight with my mother. She poisons me and gives me sexual feelings. I studied, but did not find a job. I smoke a lot, all day. [...] I wanted to be a singer, like Michael Jackson. I always sang beautiful. When I got some clothes, I was proud. My mother asked me if I wanted to be a swimmer, but I didn't. She wanted me to go to a boarding school, but I wanted to stay with my grandfather. I stayed in my room once, drank shit and urine. In X. (Belgium) I was in an institution and got rid of my alcohol addiction by putting sand in my arse.»*

> *«In London, on vacation, I was restless. I was always restless on vacation, except in Spain. We shopped in London; we saw Big Ben, Windsor Castle. We have, my mother and I, asked for asylum in Belgium. What my mother wanted, I don't know. We didn't obtain asylum. I will never know what that meant. When I was twenty-eight, I had a boy friend, but the relationship came to an end, because my mother didn't want me to have a relationship. Perhaps I cannot cry. My mother is an arse hole. She wants to brainwash me. My brother is a farmer; he has eighty cows and forty hectares of land. I never saw the money, I don't know if it is still there. I can remember my whole life. My mother and my brother were never the real ones. I masturbate once a week, I make myself up twice a day, I wash myself everyday, I think that men come to my bed every night. They do sexual things with me. I am not aware of it. My mother told me that my cousins will inherit five hundred thousand guilders, but they are of the same age as I am. My mother wants me to be dead now. My brother... his voice sounded harsh on the telephone. I don't call him. Maybe he will kill himself with sleeping pills, but I will be killed and that is not funny! I have to fight for my life. [...] Once I thought of taking a little ladder and lying down under a bull. Then I had to go to the isolation room. I did not smoke, but when I came here I became addicted to smoking.»*

> *«Once, I sat in my mother's car on our way to Belgium and she crashed the car to tease me. I was a child, I always had to say: Keep your distance. My mother was in this hospital only for one day. I had to do everything by myself at home. I cooked for my mother too, but she thought it was not enough what I prepared and then she would not eat. [...] I am afraid of being killed. Now, I have some pleasure in my life and I want to die of old age. [...] It is like this: the world is the tower of Babylon, the world came to an end and Adam and Eve will come and I think that because I am Rosa, the smartest of all people, I have to be killed. I have to be killed; I am a kind of sacrifice. I also think that girls cannot have sex, because they are unluckily built. The world has come to an end.»*

The stories of death and torture are connected to stories of sex and rape. Her mother and her brother, who seemed to have privileged access to her body, raped Rosa. This convinced Rosa that women cannot have sexual pleasure and are not allowed to enjoy their sexuality. Yet, Rosa was obsessed with sex. She dreamt about it, she masturbated (even in a public phonebox) and she told stories about sex and terror. Her mother also caused these obsessions:

> *«I think I will walk naked in the ward. The nurse will come and kick me, because I am naked. It's all because of my mother and my brother. I think that I will scream then. The police will kill me then because I keep screaming.»*

To make the magic more powerful, Rosa's mother refused to give information about AIDS, when Rosa had intercourse with another patient. Rosa:

> *«My sexual feelings keep bothering me. I have got AIDS and because I have AIDS, I do strange things. My friend had AIDS, my mother told me. We had sex ...»*

Rosa did not know exactly what AIDS was. She had heard something about «a punishment for abnormal sexual behaviour» (the moral condemnation of homosexuals). Her mother committed a real cruelty. When I explained the disease to her, she felt relieved and said: «*Then I have no AIDS; my mother has lied again.*»

How could Rosa protect herself against her mother's magic? She had several means. Before she was admitted to Saint Anthony's, she became very aggressive and violent with her mother, screaming, throwing furniture and stabbing with scissors. When she was in the hospital, she became psychotic, which was a healthy answer in this context. To enter Saint Anthony's was Rosa's only possible escape from the magic at that time. When her mother continued to practice her magic and cruelties, Rosa tried to commit suicide several times. Then she was transferred to the closed ward. Sometimes the mother's power become too strong and she wants to return, but as Rosa said:

> «*When I think of her, how she only thinks of herself and how cruel she is, I want to stay here, although I feel bored to death.*»

Rosa also practised counter magic. Her repetitive stories about horror and cruelty make sure that others will protect her against her mother's magic. Her stories also become flesh and blood when she behaves exactly as she does in the stories. She not only talks about sex. She does it. The psychiatrist told me that the stories and her subsequent behaviour were meant to shock her mother. Rosa made sure that her behaviour was so blatant that it was recorded in her files or was transferred to her mother by gossip. Rosa also tried to influence and control the thoughts and feelings that her mother put into her body by little rituals that were sometimes very painful; she drank her own urine, burned herself, jumped out the window from the second floor, etc. She wrote many letters to various staff members, to anybody who wanted to read and also to me. With these letters, she tried to "avert evil."

Her story changed little throughout the years she spent in Saint Anthony's. The mythical tales that come from the Bible, like the tale about Abraham's sacrifice, the tower of Babylon tower and Eve are reversed; the male sacrifice becomes a female sacrifice, Christ becomes a female person. Other, more personal myths are feminine stories about abuse and perverse stories of rape, torture and murder. They form a litany of sorrow and pain. She lives «in a hell» and when I entered the ward, she used to welcome me with the words: «Good morning, I am going to die», or «I want to kill myself today.» What could I say? I did not know…

«*They sing about paradise, but it will never be a paradise.*» Rosa spoke these words when we were sitting on her bed in her room in the ward. She talked about her fears and experiences. The words were a cynical statement of her feelings of disappointment and powerlessness. They expressed disbelief in the powers of psychiatry to counter her mother's magic. They made it clear that she felt "fucked up." Rosa said, «They made fools of people.» She did not believe in paradise, she believed in hell:

> *«I believe in hell. When I am dead I will have sexual feelings and I will have sex when it is not permitted. I mean when the boys don't want it. I will scream and will feel randy. That's hell!»*

Rosa felt punished, because she resisted the magic of her mother. She thought she was "a creep"; «It was a creep I saw this morning! It was me!» she said when she talked about her dreams.

When she came into Saint Anthony's, she had her hopes: «I thought that I would come into a world of love. But people don't love me. If people loved me, the world would be easier.» Her life remained similar and she became anxious about what "they" would do to her in the hospital. Magic was there too:

> *«Everything focuses on Rosa. I don't trust the medicines. I am afraid that they are poisoning me. I am afraid that they tamper with the medicines. Otherwise, I wouldn't have these feelings.»*

Rosa was well aware that there is no hope for a better life. In the end, her only paradise will be death:

> *«I like to be dead. I like to be dead. I want a happy end. However, some people say that when one dies one will keep the feelings. But I think that there will be a new life.»*

The consequences of the magic are clear. Rosa could not swallow her mother's magic. She had to make her own magic, through her stories and through her behaviour. But neither could she digest the care in Saint Anthony's. Taussig (1993) states that one can protect oneself against fearful images and remembrances by recounting them. Rosa did so in a very special way. She narrated in a special rhythm, often reading from a piece of paper with an unmoving face. It was a performance of immense suffering without the actor being involved. In her stories, she had to dismember her different body parts from the body as a whole. She opposes her head and her sexual organs. By opposing these two body parts, Rosa is able to perceive herself as a woman, even when her mother raped or conjured her: everything happened in her head.

Beyond the case

At the time that I wrote Rosa's complete story, a television programme called "Big Brother" was very popular in the Netherlands, as it was in other countries of Europe and in the US. The premise of this infotainment was that young people lived together in a house and that they were filmed night and day. The camera's eye watched the people. This idea of "watching" is not new. God is also watching us. This was pictured in a triangle with an eye in the Catholic primary school I attended when I was a child. The teacher used to threaten us by saying that God "sees everything", as if he had persuaded God to control us in his name. In Orwell's *1984* "Big Brother" is also watching. Many people sometimes have the experience of being watched by an unknown "somebody" when they feel the power and control of bureaucracy. Another example is the medical gaze in and through the body. The day and night supervision in closed wards of mental hospitals is also a form of this watching. Parents watch their children on the beach or in the streets. The issue is not the fact of watching, but when "watching" becomes a power, which controls and manipulates people in unacceptable ways. It is obvious that socially acceptable feelings of being watched have their pathological pendant. In Rosa's story, the theme of "being watched" and "seeing everything" is embodied in her own mother, who Rosa calls a "clairvoyant", and accuses of being the cause of suffering. The irony is that Rosa was transferred to the closed wards of Saint Anthony's by the psychiatrist "to keep an eye on her" after several attempts to commit suicide, so that it is not only her mother, but also the staff of the ward that are watching her. The theme of "being watched" and "being steered" is a usual theme in mad stories. The people of Saint Anthony's were watched by supernatural powers that sometimes had the name of a God, a spirit or a ghost. There were the dead – Hitler, Christ or ancestors – who haunted the patients and performed magic on them. Sometimes it was machines, like computers or electric machinery that had magical powers. This theme also seems to be universal (cf. Obeyesekere 1990; Littlewood & Lipsedge 1989; Podvoll 1990, and many others). The theme is similar to "delusion". If there is a mark of madness, this mark is surely "delusion". However, as Boyle (1990) argues, it is extremely difficult to distinguish 'normal' from 'abnormal' false beliefs. The idea that one can understand how such abnormal false belief systems came about in terms of the person's background (cultural or social) would be 'absurd' and 'dangerous' (Boyle 1990: 213). It would be better to ask why so many people – globally – have the experience of being watched and being steered, and what those experiences may say about culture and society. I will not embark on this debate in my paper, because my focus is on the performance of magic.

The power and effect of the magic performed by the gods, the ghosts, the dead or 'psychiatry' are – not surprisingly – greater than those of the magic performances of the schizophrenic people themselves. That does not mean that they are totally helpless. They perform with well-known means. For example, the use of vitamins – in liquid or pill form – is not so strange in Dutch society and many other societies as well. People believe that vitamins have the power to strengthen their bodies against intruders (viruses and microbes) that cause evil (disease). This is close to the position of Tambiah (1968), who argues that magical activities are an interpretation of technical activities with which they have a relationship (p. 198-203). In Rosa's case, the vitamins were used to protect her against danger (according to the mother), but Rosa said that her mother's feelings would cause her death: «*My mother wants me to be dead.*» In the belief of Rosa's mother the magician will cause a «culturogenic death» (Hahn & Kleinman 1983), like voodoo, sorcery, or fright. In Rosa's belief it is the mother. There is a similarity between the 'culturogenic ghosts' (the magician and the substance from the mother's stomach) and the 'pathogenic ghost' (the viruses and microbes). The magic of both the mother (vitamins and even psychotropes) and Rosa (her story and behaviour) become ritualised, a ritual that derives its significance from the «interplay and contrast with other practices» (Bell 1992: 90). From this viewpoint, it would be possible to rank magic practices according to the efficacy and power they have, if one takes into account the position of the "magician". For Rosa's mother, magical activities are "technical"; for Rosa they are words.

These words are familiar symbols, metaphors and myths that are taken from religion, and other important domains in life. Yet they are not considered as sacred words. Again, the problem raised by mad stories/mad words does not concern their content but how they differ from other uses of words and deeds (literature, for example). It seems that mad people often suffer more from this difference than from their illness.

A nurse at Saint Anthony's once remarked: «*These people are walking stories*». It is tempting to compare mad stories with literature, because they show similarities in nature, themes and sometimes even in consequences for the teller (cf. Rushdie 1990). For example, Rosa's story and life is actually about the grand theme of love. It is not the romantic love, which is often dished up on radio or television, the 'quest for happiness'. Her love is also about power, perversity, possession, fear and hate. Rosa shows that it is extremely difficult to resist someone who tells you that she loves you. Her story shows that people may say, «I love you», and then kill the beloved. "Walking stories" show – in a very real way – the magical powers of people, because they are not books that can safely be stored on the shelves; they have consequences for themselves and for others. However, their magic is a *perpetual motion machine*, simply because the «powers that be» are too great and cannot be controlled.

Turtling further down into culture

The stories of mad people are a more powerful testimony to the work of culture (and the work with culture) than other stories may be, because they come to life. Not only can one listen but one can also see, feel and smell. Take Eric, a schizophrenic patient in the closed wards. When he is in the isolation room – on his request – he can be seen mumbling, yelling «no, no, no» and trying to protect himself from something or somebody. This alerts staff members. Later it became clear that Eric had to defend himself against Eve's erotic advances (the story of Eve, the snake and the apple). Stories and lives of mad people switch from the common and acceptable to hidden and unacceptable emotions, human interactions and effects of cultural practices. We do not like what we see in mad stories.

But what does this tell us about culture? How can the foundations of a culture be found? A Navaho answer to this question illustrates that there are different perceptions of reality, which are as common as ours: «It turtles all the way down» (Geertz 1973). Where it will end, one does not know. This uncertainty is frightening in a culture such as the Dutch one, which stresses control and minimisation of risk. Crazy stories are not neglected, but they will remain vulnerable to dismissal from different sides. Psychiatrists explain the stories as symptoms of madness. Students of literature may perceive such stories as too confused to be literary. Movements for empowerment may see the stories as too unsystematic to be counterproductive.

Working with mad stories needs concepts other than 'schizophrenia' or 'psychosis' as researchable phenomena. It brings the researcher to sadness, grief, melancholy, unhappiness, loss, joy, pleasure and all the concepts that are so common to experience and which are spoken about in human life, but so uncommon to science. They bring the idea that «not rational choices but embodied practices express the poetics of suffering» (Kleinman 1996: 287).

Mad stories are embodied stories in a moral space. They are culture specific in their expression and themes, but universal in what is at stake. The tellers of the story suffer because they are targets of social and medical interventions that – in the end – turn out to be powerless. This – in turn – is a serious obstacle for the people and their stories. There is a lack of plot in which the teller gets better. In many illness stories the tellers have overcome their illnesses or the burden of their illnesses. Their suffering was not for naught. They learned. In these crazy stories people do not say that they have 'learned' or that they have got 'better'. On the contrary, they are stories of fear, hopelessness, the accumulation of suffering *and* vitality.

They counter fundamental cultural values: hope, quest for change and the all too optimistic belief in the power of humans. In short, they challenge the «idealisation of happiness», the myth of «the good life» (Farber 1976). They show that the world «will never be a paradise» and that the quest for the Holy Grail is maybe more important than the icon itself, even at a high cost. According to Lévi-Strauss (1973), this is a powerful myth, because it does not have a question. This may be extremely bewildering in a society in which people stress control and minimisation of risk.

The message of mad stories is clear: they counter the optimistic ideology that medicine provides 'answers' to illness and is able to control life. The question is also clear: what can we do when illness cannot be 'cured' or 'controlled'? This is a question that becomes all the more urgent in an era of increased chronic illness and suffering.

'Chronic schizophrenia' is like many other chronic illnesses, a concept that shows how, why and when society cares and whom it cares for. Estroff (1993: 251-252) tackles an important question that, according to her, lies at the core of a culture: «[Can't or won't we] respond to these persons in rehabilitative and restorative ways?» Are we unable or are we unwilling to do so? According to the author, this controversy underlies the ambivalence in the West about people who are chronically ill and disabled. The author continues her argument by saying that we cannot tolerate defiance of functional requirements, but neither can we punish or neglect people who are unable to contribute at an expected level. Society (that is, the people in society) becomes the victim of its own cultural constructions: it accepted the 'sick role' but it has a problem with a lifelong condition of being excused. Estroff 'turtles' even further down: society has a problem with the ontological status of illnesses. Are they real or unreal, visible or invisible? These are very important questions that need to be answered. However, I would like to stress that her argument can even 'turtl' further down.

Encounters between mad people and 'those out there', like the case of the mechanics across the street or the people in the bars, are markers of inconsistent and context dependent dos and don'ts. Forces of mad people and others clash. What has to be suppressed comes to the surface (e.g. intolerance, cruelty, perversity). Such moments make clear that cultural myths «are basic lies that make life possible.» Necessary lies, because «if something cannot be used to tell a lie, conversely it cannot be used to tell the truth: it cannot in fact be used 'to tell' at all» (Eco 1979). Mad people are too aware of the basic lies. But cultural models, myths and stories are powerful survival kits that can be used to reflect on dangerous and critical situations.

The suffering in madness is sometimes all too overwhelming. The people use their energy and creativity to survive; they are not pathetic victims. They complain of 'empty minds' or 'loss of their soul'; they say that there is little going on in their minds. But they are still alive and their stories show that they have to work hard.

If magic is the «domain of desire» (Gil 1985), it is clear that the desire within the stories and actions of mad people is expressed in «floating signifiers», explanatory principles for «mad thoughts». The «quintessential force» (Mauss 1960) is *mana*, everything and nothing, that opens up (according to Mauss) the passage from one code to another (and is the result of a force). Mad people have to make others move from one state into another. And they do, as we will see below.

People's magic lacks efficiency from an outsider's perspective, unless they look at the changes in their lives that could make them less isolated from the day-to-day world. This group of chronically ill people shows that the assumption that 'culture's magic' is a great deal more efficient at controlling the powers of madness than 'people's magic' at controlling lives is not always true. The basic cultural belief that life is a project, which can be controlled and modelled by human beings, is affected by the discrepancy between the power of people and the power of culture (as a human construction). The power of mad people is that they are often perceived as "dangerous" and "angry", especially when they are psychotic. I observed that many people in the closed wards often had deep, yet understandable, anger and when they became psychotic this anger was manifested in impressive and sometimes fearful ways. Not that I want to stress the violence of mad people, but anger and violence have tremendous power over others. Not only in the wards, but also in the outside world, they are the reasons for calling for the assistance of the police and mental health care emergency teams. Maybe the violence is the "real" magic?

Mad people make themselves a life through their magical use of myths, models, symbols and themes of culture, but their stories clearly show that there is a limit to the understanding of and coping with 'the differences within'. Here, the questions «can't we?» or «won't we?» are raised again. I have no clear answer to these questions. Maybe Laing (1967) is correct when he writes: «If the human race survives, future men will, I suspect, look on our enlightened epic as a veritable Age of Darkness…» They will see that what we call 'schizophrenia' was one of the forms in which, often through quite ordinary people, the light began to break through the cracks in our all-too-closed-minds. Are minds too closed for other forms of life?

Do people fear those forms? Why? Can't we live with 'doubles'? Mad people, like Rosa and Lisa, are not the only ones who reassert themselves against cultural ambiguity and ambivalence. People have to struggle with stabilising patterns opposed by the force of subjectivity. Do they fear that the troubles they have with such a life will lead to despair and hopelessness? Mad people provide a 'lesson'. They challenge the notion of suffering, a well-known concept in medical anthropology. People are able to survive, even with hopelessness, as long as they can tell their magical stories. They will repeat their stories that are means to break «a closed mimetic circle of repetition in culture by wildness and leaning against the wind» (paraphrasing Taussig 1993). When the story comes to an end, lives of mad people will also end. The last words of Rosa were:

> *«Now I write letters to Jo, the woman in the hobby centre. I have to, but I think: I should not write, because I am afraid that people will think that I am weird.»*

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THERAPEUTICS

AM
Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 335-349

Medicinal plants and rituals.

Magicotherapeutic and magicoprophylactic plant uses in Pallars (Pyrenees, Catalonia, Iberian Peninsula)

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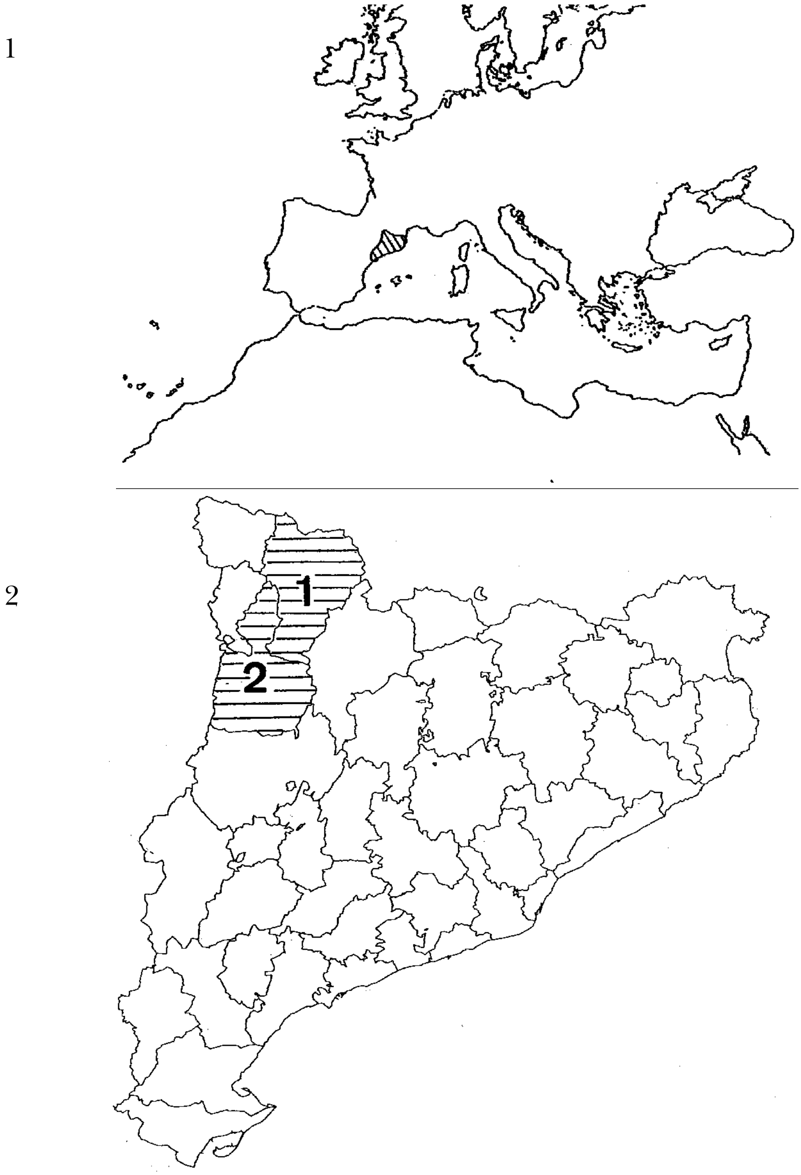
Introduction

Plants for medicinal and food purposes have been used by human societies since time immemorial. In the last two generations, so-called developed countries have undergone a process of acculturation (Ember and Ember 1997) – parallel to the depopulation of rural areas –, which has led to considerable erosion of traditional knowledge about plant uses. Aware of the precariousness of this knowledge, which is both a part of our cultural heritage and relevant for developing new medicines and other benefits for the population (Croom 1983; Hedberg 1993), several groups have done research into pharmaceutical ethnobotany over the last few years in European countries (see Vallès and Bonet 1996, Raja *et al.* 1997, Vallès 1997, and Bonet *et al.* 1999, for more details and references). With the same idea, and in the frame of the research line into Catalan ethnobotany of the Laboratory of Botany (Faculty of Pharmacy, University of Barcelona), we carried out a study in a Pyrenean region called Pallars (Agelet 1999). Here we present the results concerning the magical uses of medicinal plants, which involve some kind of ritual.

The territory studied (Fig. 1) is constituted by two mountain districts located in the Pyrenees: El *Pallars Jussà* (or el *Baix Pallars*) and *El Pallars Sobirà* (or *L'Alt Pallars*). Both areas together are known as *Pallars* and are defined by the river Noguera Pallaresa, which crosses them from north to south. El *Pallars Sobirà*, a clearly Pyrenean district, with several peaks around 3,000 m, has an area of 1,376 km^2 and a population of 5,050. El Pallars Jussà, basically a sub-Pyrenean district, with some peaks around 2,000 m, has an area of 1,290 km^2 and a population of 13,760. The predominating climate is sub-Mediterranean, but alpine, sub-alpine climates characterise the northern portion of the territory, and the Mediterranean climate is

Figure 1. - Location of the areas studied in Europe and in Catalonia (shaded areas; 1: El Pallars Sobirà; 2: El Pallars Jussà).



typical of the southern plains and nearby Sub-Pyrenean Mountains. Rainfall ranges from 600 to 1300 mm/year – snow being a normal phenomenon in many zones – and temperatures oscillate between – 31C (January) and 41C (July). The altitudinal and climatic variation cause a highly diverse vegetal landscape with forest as the main vegetation.

From the second half of the 19th century, the population in Pallars has constantly decreased, and has reduced from more than 50,000 in 1850 to the present 19,000 (Sabartés 1993). This process has been particularly dramatic since 1960. People have left the region to migrate to large cities, like Barcelona, the capital of Catalonia, or large villages. The depopulation has been a current trend in rural areas in the country, especially in the mountains, of which Pallars is one of the clearest examples. Relative isolation has been added to the problems of the people in Pallars. Until recent times, the communications network (roads, railways) was very inefficient. This caused El Pallars Jussà and El Pallars Sobirà to be two rather marginal districts in the Catalan economy. Both areas belong to the socio-economic territorial unit called the Catalan High Pyrenees (Carreras 1983), which comprises the main mountain zones in the country. Agriculture and livestock are the basis of the Pallars' economy, even though the tertiary sector and other activities such as iron mining and forestry are also important.

Various authors have contributed to the study of ethnobotany – in the wide sense – in Pallars. Among them, Ramon Violant i Simorra has been particularly active. He was born in Pallars and he studied his region before the great depopulation. His numerous articles, published between 1930 and 1960, have been reedited together (Violant 1979-1981). We can also cite the works of Griera (1923-1964), Llensa (1946, 1950, 1953, and 1959), Font (1948, 1961), Lluís (1967) and Amades (1982). Nevertheless, data concerning popular uses of medicinal plants are scarce and often insufficient.

Methodology

Information was obtained by the method of the ethnobotanical interview with people born or having lived most of their lives in the region. They were usually elderly. We assessed how people used plants for health purposes through general conversations with open questionnaires. We asked people to collect plants with us and to show us where and how they stored the plants and how they prepared the remedies. If it was not possible to collect plants with the informants, we showed them specimens we had collected ourselves in the region to confirm the identity of each taxon. We avoided asking direct questions that could prompt an implicit answer, so as not to coerce the informants and decrease their spontaneity. We verified that many people are highly influenced by these questions and very often simply tend to answer yes. Whenever possible, the conversations were recorded and, once back in the laboratory, transcript. The field and laboratory work lasted more than five years, during which time we performed 155 interviews with 264 people between 30 and 101 years of age (mean age, 70 years; 48% women, 52% men) living in 120 population units. In most cases, there was more than one interview session; the total time of interview recorded is 395 hours. Voucher herbarium specimens of every taxon cited were prepared and deposited in the Herbarium of the Laboratory of Botany, Faculty of Pharmacy, University of Barcelona (BCF). Complete records of the interviews are also kept in this Laboratory. Further details of the interviews are given in the doctoral thesis of one of the authors (Agelet 1999). For plant nomenclature, we follow Bolòs *et al.* (1993).

Results and discussion

Plants involved in magic rituals

We documented a total number of 437 species with uses in the field of health in Pallars. Forty of them are used with magicotherapeutic and/or magicoprophylactic purposes, in most cases with a ritual component. These 40 taxa are listed in Table 1, with their claimed properties. We considered plants to be magicotherapeutic or magicoprophylactic if they had a use and a process that fell into the category of magic or sacred, as usually understood in the cultural anthropology sense. We followed the statements of Frigolé *et al.* (1983) – and similar reflections by other authors such as Caro Baroja (1966), Evans-Pritchard (1976), Hoebel and Weaver (1985), Barandiarán (1991) and Eliade (1994) – that the object of magic practices is the direct coercion of mystic powers with the intention of acting on the material world, whereas religious practices deal with supernatural powers that can be supplicated but not manipulated.

Only two of the species cited in Table 1, *Carlina acanthifolia* and *Salix viminialis*, are strictly used with magical connotations; the others also have therapeutic or prophylactic uses but are not linked to magic practices. Indeed, a good number of the plants used with magicotherapeutic or magicoprophylactic ends have a wide spectrum of folk uses and are very

Table 1. Plants used with magicotherapeutic or magicoprophylactic purposes in Pallars

Scientific name	Catalan names in Pallars	Medicinal activity
Abies alba Mill	Avet	Illness preventive
Alchemilla alpina L.	Herba desinflamatòria, peucrist	Antimycotic
Allium ampeloprasum L.	All bord, all de bruixa, all de serp	Ophidia repellent
Allium sativum L.	All	Antiverrucose, antiseptic, illness preventive, ophidia repellent
Amelanchier ovalis Medic.	Corner, cornera, cúrnia	Illness preventive
Arundo donax L.	Canya	Protective against ophidia
Asplenium trichomanes L.	Falzilla, herba de la pressió, gitana, herba pigotera, sardineta	Antimycotic
Avena sativa L.	Civada	Acaricide, antiverrucose, antieczematose
Buxus semprevirens L.	Boix	Antiverrucose, anticholagogue, ocular antiseptic, illness prevention
Carlina acanthifolia All. subsp. *cynara* (Pourr. Ex Duby) Arcang.	Card, cardigàs, cardimells, cardot, carlina	Illness preventive
Clematis vitalba L.	Vidalba, vidigarsa, vidiguera	Antiseptic
Eryngium campestre L.	Panical, pixallits	Antiseptic
Euphorbia characias L.	Lletera, lletrerola, escampador	Antiverrucose
Ficus carica L.	Figuera	Antiverrucose, galactofugue
Fraxinus excelsior L.	Freixe, freixa, freixera	Ophidia repellent
Hordeum vulgare L.	Ordi	Buccopharyngeal antiseptic
Hyssopus officinalis L.	Hisop	Vulnerability
Inula helvetica Weber	Àrnica, àrnica borda	Illness preventive
Juglans regia L.	Noguer, nouer	Hypothyroidic, illness preventive
Juniperus communis L.	Ginebre, ginestre	Antiverrucose, antihelminthic, antiophidic, antiseptic
Juniperus oxycedrus L.	Ginebre	Antiverrucose
Juniperus phoenicea L.	Savina	Antiseptic, illness preventive
Laurus nobilis L.	Llorer	Antiseptic, illness preventive
Lavandula angustifolia Mill. subsp. *pyrenaica* (DC.) Guinea	Botja de Sant Joan, herba de Sant Joan, Botja de Sant Pere, espígol, d'estiu, espígol d'obaga, espigoler	Antiseptic, illness preventive
Medicago sativa L.	Alfals, sanfuén	Antitympanitic
Olea europaea L.	Olivera, oliver	Antipyrotic, illness preventive
Plantago lanceolata L.	Plantatge, plantatge de fulla estreta, panyatge	Buccopharyngeal antiseptic
Prunus dulcis (Mill.) D.A. Webb	Ametller	Anticephalalgic
Quercus humilis Mill.	Roure	Hernia reducer
Quercus ilex L. hernia reducer	Alzina, alzinera	Antiverrucose, illness preventive,

Segue tabella 1

Table 1. (Cont.)

Scientific name	Catalan names in Pallars	Medicinal activity
Rosa canina L.	Roser silvestre, gavarrera, gavarrera blanca, gavarrera roja	Antialopecic, antiverrucose, antimycotic, larvicide, illness preventive
Rosmarinus officinalis L.	Romaní, romer	Illness preventive
Rubus ulmifolius Schott.	Barsa, barser, barsera, esbarzer, barsa	Antiverrucose
Ruta chalepensis L. subsp. *angustifolia* (Pers.) Cout.	Ruda	Oxitocic, illness preventive
Salix viminalis L.	Vimenera	Antiverrucose
Santolina chamaecyparissus L. subsp. *squarrosa* (DC.) Nyman	Botja, botja de Sant Joan, botja balnca, camamilla, camamilla borda camamilla del terme, camamilla de roc, camamilla silvestre, flor de Sant Joan, flor de Sant Pere	Antiverrucose, antieczematose, antiseptic
Scirpus holoschoenus L.	Junc, junços	Antiverrucose
Secale cereale L.	Séguel, blat	Antiseptic, buccopharyngeal antiseptic, phytoregulator
Triticum aestivum L.	Blat, forment	Buccopharyngeal antiseptic, ocular antiseptic, phytoregulator
Vitis vinifera L.	Vinya, cep, parra	Antiseptic, diagnostic of whitlow

polyvalent. Among them, *Allium sativum, Fraxinus excelsior, Quercus ilex, Secale cereale, Triticum aestivum and Vitis vinifera* may be cited for their high pharmacological and sociocultural values.

Types of magic uses of plants

The 26 types of magicotherapeutic or magicoprophylactic uses recorded are presented in Table 2. The diseases treated with magicoreligious practices are described by the informants in very generic or ambiguous ways, which sometimes makes it difficult to make a correct classification. The plants were mainly used for antiverrucose and antiseptic purposes as well as illness prevention. These are very common illnesses, with considerable collective repercussion (and which are, of course, also treated with medicinal plants with no magical connotations). Some kinds of illnesses are never treated with a magicoreligious component: abnormalities; blood and circulatory system problems, immunity, metabolic, respiratory and nervous system diseases, nutritional disorders and neoplasias.

The uses found show a high degree of agreement with those reported in neighbouring territories, such as the Huesca province (Villar *et al.* 1992), or some of its parts (Serrablo: Navarro 1994; Monzón district: Ferrández

Table 2. Activities of the 40 plants used with magicotherapeutic or magicoprophylactic purposes in Pallars.

Type of use	Number of species	Percentage (of 40 species)
Acaricide	1	2.5
Antialopecic	1	2.5
Antiverrucose	13	32.5
Anticephalalgic	1	2.5
Anticholagogue	1	2.5
Antieczematous	2	5
Antihelminthic	1	2.5
Antimycotic	3	7.5
Antiophidic	1	2.5
Antipyrotic	1	2.5
Antiseptic	10	25
Buccopharyngeal antiseptic	4	10
Antitympanitic	1	2.5
Diagnostic of whitlow	1	2.5
Galactophugue	1	2.5
Hernia reducer	2	5
Hypothyroidic	1	2.5
Illness preventive	15	37.5
Larvicide	1	2.5
Ocular antiseptic	2	5
Ophidia repellent	3	7.5
Oxitocic	1	2.5
Phytoregulator	2	5
Protective against ophidia	1	2.5
Vulnerary	2	5
Non determined	1	2.5

and Sanz 1993), the region of Cerdanya (Muntané 1991, 1994, 1996) and the river Tenes valley (Bonet 1991, 1994). Some of these areas, like Pallars, are also Pyrenean. A magic use also coincide, but to a lesser extent, with other zones of Catalonia (Gomis 1987; Parada 1997; Selga 1998), the Iberian Peninsula (Junceda 1987; Barandiarán 1991; Mulet 1990, 1991; Blanco 1992; Fernández 1996; Garmendia 2000) and Europe (Frazer 1944; Graves 1983; Lieutaghi 1991; Ribon 1993; Bonnefoy 1998; Pieroni 1998).

In general, there is a clear correspondence between uses and types of medicines: a very high number of magico-religious practices (around 77% of those recorded) are linked to only one plant and to one specific ritual. The typology of the phytomedicines used in magic processes is the following: 1) one plant (64.21%); 2) mixture of two or more plants (3.15%); 3) plants(s) + plant product (2.1%); 4) plant(s) + animal product (2.1%); 5) plant(s) + inorganic product – usually a stone or a cutting implement – (5.26%). The predominance of simple (one-plant) medicines agrees with the situation in non-magic folk phytotherapy, where these medicines are also the main group (around 55%), but the highest value in the case of magical practices can be seen as a distinctive feature of plant medicine linked to specific rituals. On the other hand, the number of different types of drugs is much lower in ritual practices than in general plant-based folk medicine. Mixtures of different plants often take the form of protective bouquets. This tradition is very old and deeply rooted in rural communities. Our data from Pallars agree with those reported by Violant (1979-1981), Pujiula (1983), Bellmunt (1990), Fourasté and Fourasté (1990), Villar *et al.* (1992), and Roigé *et al.* (1997) from other Pyrenean regions, and with those from other geographical areas (Aiats *et al.* 1984; Arnold-Apostolides 1991; Lieutaghi 1991; Blanco 1992; Ribon 1993; Fernández 1996; Bonnefoy 1998). Protective bouquets prevent illnesses and adversities in general, and are, according to Harris (1974) for historical reasons, often associated to a belief in witches. Witches, persecuted by the Inquisition, became the incarnation of damage, misfortune and evil. The name of one of the species used in Pallars (*Allium ampeloprasum*: *All de bruixa* -witch garlic) is a remnant of this belief. Other species, such as rue (*Ruta chalepensis* and related taxa), are often associated with witches (people say that they are witches similar to herbs). Most protective bouquets in Pallars (around 73%) are linked with Palm Sunday, when they are blessed. They are mostly placed in doors or windows, because people believe that these are the points through which illnesses and troubles enter the home.

Factors associated with magical uses of medicinal plants

The parts of the plants used or the period of administration of medicines are often regulated by numbers (basically 3, 7, 9, and other odd numbers). This is also a ritualistic element, which is not limited to only the 40 plants with magic uses. For instance, 109 of the 410 (26.6%) plant species claimed to be medicinal in Pallars are administrated in so-called *Anovenes*, periods of nine days (nine days taking the medicine and nine days without it, or nine days increasing and nine days decreasing the doses, or other similar models). This agrees with the studies of Peris and Stubing (1993), Gavilanes (1995) and Bonet *et al.* (1999) in other areas. The use of herbal remedies is also often associated with prayers, as Martí (1989) pointed out. In the region studied, these prayers are not very common in connection with plants, although some of them are said during processes involving phytomedicines. Nevertheless, medicinal prayers exist independently of magic plants, and constitute another kind of therapeutic or prophylactic resource.

Two case examples

As two case examples, and with the help of illustrations (Fig. 2-7), we report the sequence of two particular rituals in Pallars magic medicine linked to plants. The first one (Figs. 2-4) is the operation named *Atallar* (aristó),

Figures 2-4. *ATallar l'aristó*. 2. A piece of wood is placed on the affected leg. Three grapevine (*Vitis vinifera*) stems, each one with three knobs, are placed on the wood. 3. The ritual officiant cuts the three stems in the three knobs. While the knobs are being cut a prayer is recited. 4. If the stem fragments jump when the officiant cuts them, this means that the animal is ill and the stem fragments have to be burned.

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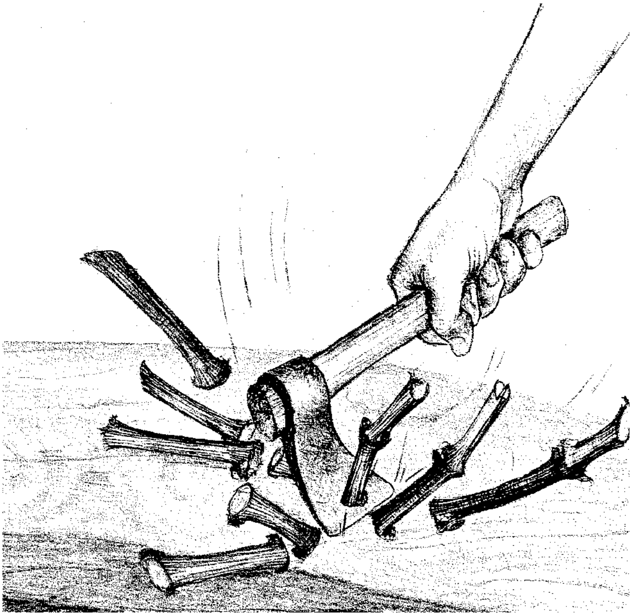

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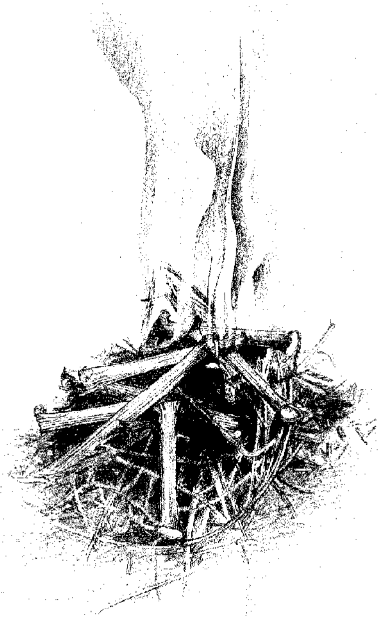

which consists of the magicoritual treatment of a chronic articular infection in animals or people. We exemplify the operation in sheep. The second one (Figs. 5-7) is the operation known as *Aixafar la gavarrera*, a ritual used to treat miases in animals or people.

Concluding remarks

In Pallars, magico-therapeutic and magico-prophylactic plant uses are based, as Coppo (1998) described in some African societies, on a cause-effect sequential chain, and on a set of analogies, coincidences, similarities and intuitions. In our experience, the main features of magicoreligious practices linked to the plant world in the region studied are the following:

Figures 5-7. *AAixafar la gavarrera*. 5. The officiant looks for a wild rose (*Rosa canina* and related species) and collects nine stones approximately as big as a wrist. He/she takes his/her shoes off, makes the sign of the cross and treads on a branch. 6. The officiant kneels on the rose and places the stones on the branch. 7. The officiant recites the *Pater noster* three times. Finally, when the animal or the person has recovered from miasis, the officiant must remove the stones from the branch.

5

6

7

1) Predominance of syncretic and eclectic practices.
2) Magic mentality as a set of naturalist and animist patterns, associated with materialist and pragmatic attitudes and, often, with supernatural beliefs.
3) Effectivity is based equally on the plants used and on folk beliefs and the associated ritual processes.
4) Preponderance of prophylactic and therapeutic practices.
5) Protective bouquets are one of the most significant elements. They are used as amulets and considerably varied in composition and uses.
6) Association between most practices and processes of identification between the disease and the plant, to which the illness is often transferred from the person.
7) Frequent association with saints mostly Saint John.
8) Low incidence of prayers.
9) Presence of particular (mostly odd) numbers, especially 3, 7 and 9.
10) Most of the magic plants are cultivated or favoured by the traditional agricultural system.

Acknowledgements

We are very grateful to all *Apallaresos* who were willing to share with us the treasure of their knowledge on plants. Anna Serentill is thanked for her expressive drawings (Figures 2-7).

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 351-372

Dance as drug, dance as medicine

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The aim of this cross-cultural field study is to reveal the health-related contents of contemporary folk and popular dances. When comparing dances with different cultural contexts and different kinesic "grammar" such as free improvisatory solo or group dances (disco, rave), one can also trace differences, from the medical anthropological point of view, regarding issues of health, risks and healing.

As these dances may form different "body-speech" communities explorable by social anthropological methods, dance communities are examples of universal medical anthropological problems such as embodiment of cultural values regarding health and risk, coping with problems of a lifestyle with less physical activity and more emotional distress, or daily hassles. Distorted coping styles such as drug use in dance communities is discussed, involving the "drug role" of dance in altering mood and consciousness too.

Exploring the narratives of our informants, dance is revealed to have a role in creating better moods, joy, fitness, better living and social support, all of which are health promoters.

Health psychology has proved that joy, happiness, fun and a positive mood are important in health protection (e.g. positive psychoimmune effects, protection of cardiovascular status), so dance is a source of health. On the other hand, some forms of dance are attached to a particular lifestyle and the coping distortion, like drug use, smoking and drinking, may not promote health, as is the case of some youth subcultures (chemical generation, acid rave etc).

Dance may be medicine too. We examine dance therapy in its psychiatric context by means of field study and interviews with therapists.

Although folk and popular dances have an important relation to health, they are not part of the general practice of dance therapy. Unlike mind/body centering, or dance and movement therapy, which are supported by psychoanalytic developmental theory and by the diagnostic/analytic tools provided by the Kerstenberg Movement Profile (KMP), popular and folk dances have no such analytical background and cannot be considered to be a theoretic interface to biomedicine. Psychophysiological, etic analysis may provide these missing elements. The medical anthropological interpretation may help to bring dance closer to the medical discourse.

In the Cartesian Gulf: what is medical in the anthropology of dance?

Medical anthropology has to contend with the problems of the Cartesian mind/body dualism in its dealings with symbolic healing, psychosomatic phenomena and the anthropology of the body. Dance has important in its own right in this framework because it has a multilevel, biocultural adaptive role as a social practice. The fact that dance has induced limited interest among social scientists may reflect the extent of this Cartesian gulf between verbal culture and physical culture that involves non verbal communicative systems (Polhemus 1993). This prompts us to reconsider our exclusive logocentrism, and the reintegration of the "bodily logos" (Sheets Johnstone 1983).

On the other hand, references to dance can be found throughout the history of anthropological literature: for example, from Spencer (1857), Marret (1914), Radcliffe-Brown (1922), Evans-Pritchard (1928), Franziska Boas (1944) and Mead and Bateson (1942) up to Blacking, Lomax, Williams, Lange, Hanna and Thomas and other contemporary anthropologists.

However, the health aspects of dance are not represented as a main theme in the mainstream discourses of dance research. Giurchescu and Torpe compared continental European choreological and American anthropological perspectives on dance, emphasizing that the anthropological approach concentrates on "dancing people", while European choreology deals with comparative research, systematisation and classification of the observed dances. After the Second World War, folklore theories in Europe were directed towards studying "dance reality" in its social and artistic dimensions (Giurgechscu and Torpe 1998), while Alan Lomax's cross-cultural Choreometrics Project extended American anthropology. It is obvious that the hidden "biocultural" functions of dance are even less articulated in these monographs. In addition, less attention is directed towards the health aspects of folk and popular dances, and other non ritual everyday dance and musical social practices.

To reveal the health related aspects of dances we need the “tales of dancers”, and the experiences of those who learn, teach, research dances or even heal by dance. The personal experiences of the observer with these dances are just as important as the reports of others.

Should we base the study of dance on earlier anthropological interpretations? Dance can be seen as a kind of catharsis, or release. Maybe the first anthropological concept of dance also had a covert health psychological framework. Spencer (1857) called dance a «safety valve for releasing emotional steam». This concept of tension release or repression appears in other anthropological concepts such as «release from children’s rigorous repression and subordination» in Mead’s (1928) interpretation, in a kind of «relief from the burden of actuality» (Langer 1953), in «release of tension following a period of economic anxiety» in Gluckman’s view (1959; cited by Spencer P. 1985). Dance as stress releaser, modifier of mood, source of joy, and preserver of physical fitness on a personal level may gain health related importance.

Dance builds a bridge over the Cartesian gulf as embodied social interaction, bodily language synthesising rational and emotional messages and intentions, and fills the human organism with social and cultural content, thus making the body human. The etymology of emotion makes it obvious that psychical states are experienced through bodily processes too; motions are emotional and the emotions arouse different postures and gestures deeply imbedded in the bodily logos. The intentional relaxation of the muscle system may reconfigure chronic psycho-physiological and emotional states, inducing change in the psychosomatic disease process. This can also be experienced during dancing, which directs medical anthropological interest towards the body as a bypass for solving mental and psychic problems.

Dance incorporates a wide range of evolutionary selected skills: sense of rhythm, symbolic capability, skills of innovation and variation, kinetic abilities and so on. Through dance one can gain control over one’s body, develop physical fitness and transform emotions and instincts into “linguistically patterned forms”. This skill of expression takes place at a level that is deeper than verbal exploration. This deeper bodily process of “access and reframe” may acquire psychotherapeutic meaning and importance. Health psychology has proved that joy, happiness, fun and a positive mood are important in health protection (positive psycho-immune effects and protection of cardiovascular status), so dance has become a health promoter. These clinical facts lend medical importance to dance it. Dance may be medicine.

Medical anthropological research into dance may involve health protecting aspects, health risks and healing processes by means of traditional dances and therapies as well. The medical anthropological analysis of the health aspects of dance requires a special "hermeneutic shift", a sort of "medicalisation" of the subject.

In the same way, that medicalisation turns implicit cultural health contents into explicit institutional and instrumental forms, cultural issues whose health-related content has adaptive functions may be the object of "anthropologisation" too.

As Ward reveals, «functionalist analyses are archetypically rationalist» when they give rational explanations of irrational or non rational phenomena. When we state that «dance reinforces community, it regulates, controls, constrains and conditions behaviour» or that «dance is a convention of courtship, dating and sexual bargaining», we point towards the functionalist anthropological tradition. This "etic" approach can be extended to health psychological issues such as stress management, locus of control, social support, overcoming lack of physical movement, relaxation, trauma disclosure and psychology of gender. This vocabulary may be transferred to the dance experience.

Dance as remedy for the social body

The individual bodily benefits and psychological gains may be obvious, but dance is also an important regulator of the "social body", as it can help to teach social skills, gender roles accepted by a particular society, empathy, and co operativity. Its important sociotherapeutical effect is that it strengthens the "we" feeling. Dance is a sort of body language that certainly has an important role in shaping regulated social behaviour. In traditional societies, the dialects of dance lend a cultural personality or identity to communities living together.

The cultural, social and physiological aspects of dance can be examples of bio-cultural adaptation. Hanna discusses the adaptive pattern of dance regarding mating strategy. Sometimes, according to the reports of our informants, dance can help to overcome barriers created by social rank in mate selection. Nevertheless, beyond reproductive success, dance offers other health protective advances at a personal and social level that are open to medical anthropological discourse.

Dance as cultural behaviour involves people's values, attitudes and beliefs as well. In the wider sense, the anthropology of dance and music reveals various functions such as aesthetic enjoyment, entertainment, communication, symbolic representation, physical response, enforcing conformity to social norms, validation of social institutions and religious rituals, contribution to the continuity and stability of culture, and integration into society (Merriam 1964).

In a socio-psycho-physiologic framework, dance may also mean coping with socially induced tensions and frustrations. These barriers may be overcome by the communicative function of dance, which gains political significance via the articulation of political attitudes and values. It offers a dimension of control in the otherwise submissive status of being a minority. It is more important in cases of muted verbalisation of personal or social frustrations. Anthropological analyses of narratives may help to reveal these covert functions of dance.

The grammar of dance: communication as source of healing

As Williams writes: «Dancing is essentially the termination, through action, of a certain kind of symbolic transformation of experience.» (Williams 1973 cit. Hanna 1979:23). This definition suggests that the linguistic function of dance is a «repetitious, redundant and formally organised system of body communication present in the culture» (Lomax 1968: 223). The semiotic and semantic aspects of human dance help to draw parallels between language and dance. We can explore the set of kinematic units as signs, the syntax and grammar of these "sentences" of motions, gestures and kinetic events. Compared with non-human verbal communication, human dance shows a sharp, qualitative difference mainly in its emotional transformative content, intentional rhythm and its free choice regarding psycho-biologically based rhythms. As an open productive system of movement, it is different in its semantic, syntactic, and learned arbitrary forms, while non-human non-verbal communication is a relatively simple system with limited interspecies variation. The personal experiences that dance expresses have therapeutic potential as a release of psychic tensions. This function of dance, with its cognitive and affective dimensions, is imbedded in the socio-psychological context.

Kinetic analysis may disclose "dance" to be the synchronisation of movement between people in communication. If these phenomena are part of a communication process, they may acquire an important role in forming effective and compliant Doctor-patient relationships. The video analysis of psychiatric rapport provides insight into this non-verbal dimension. As far as the definitions of dance mentioned above are concerned, however, this contact-sensitive, non-intentional, “non-purposeful” body language can not be considered to be dance. Dance as an expressive way of human communication has language-like properties. Dance structure analysis itself is a sort of disclosure of an implicit grammar of dance idioms (Martin 1982).

Ray Birdwhistell comments these features as follows: «Humans move and belong to movement communities just as they speak and belong to speech communities», «there are kinesic (body motion) ‘languages’ and ‘dialects’ which are learned by culture members just as speech is learned» (Birdwhistell in Hanna, 1979: 5). Dance is a physical and embodied form of interpersonal communication with its intensive physiological processes, and psychological concomitants.

The lost functions of changing dance practice and social activity may be conquered by health psychological activity or even by medical efforts. In my fieldwork, I am searching for these functional aspects of non-ritual popular dances in everyday life, analysing the practice, traditions and narratives of dancers. As singing is tightly attached to dancing, the researcher’s interest must extend to singing as self-healing and self-expression with latent coping functions too.

In fieldwork, I have paid particular attention to the environment of dances and their cultural-bounds. These dance fashions may form different “body-speech” communities to be explored by social anthropological methods. Dance communities are examples of universal medical anthropological problems like embodiment of cultural values regarding health and risk, coping with problems of life style poor in physical activity, fitness, emotional distress, or daily hassles. Distorted coping styles such as drug use among dance communities is discussed involving the “drug role” of dance in altering mood, and consciousness.

Our medical anthropological approach can be extended to the level of the social body, to deal with dance and cultural bereavement in the case of emigrants and ethnic minorities, difficulties of mating behaviour in urban setting, shyness, and sociophobia. Social support is thought to be a crucial factor in health protection, which is sustained, by being member of emotional communities like religious groups and dancing communities. As traditional children’s games and couple dances are useful in developing social skills, it is not surprising that we find that they are used to educate mentally retarded children and even to rehabilitate depressed or schizophrenic patients.

Methodology

This multi site fieldwork research was carried out between March and August 2000 to compare traditional, structured couple of dances like salsa and folk dances of the *táncház* (dance-house) movement in different cultural contexts. The research on Salsa took place in Oxford and San José. The research on Hungarian folk dances took place in London at a *Dance House* held by British dancers familiar with Hungarian folk dances in Spring 2000; in Hungary, in the *Dance House Festival*, March 2000 and in consecutive summer dance camps: in the Jánosi Ensemble's Village Camp at Bodajk; and at dance camps in Kalotaszentkirály (Sincrai) and Válaszút (Reascruci), Transylvania, Romania. Interviews and fieldwork regarding dance therapy were carried out in Bristol, Budapest and Szeged.

Further fieldwork was based on self-analysis, short visits, focus groups, interviews and video documentation of dance practice and the environment. The research contained experience gained by participating in the life of the dancers living together throughout the duration of the camp.

Although it is usual to make video recordings of the performances at these camps, permission for the research was always sought from the organisers and, of course, from all the informants. The interviews were taped using an Olympus Pearlcorder S710 and the dances and environment were documented using a Panasonic SVHS handycam, as a source of photographs as well as grabber and computer technology. Participant observer behaviour included the learning and practice of dance as self experience. We asked people for their permission to interview them on every occasion; permission to tape was refused in two cases.

The analysis of dancers' narratives enabled us to compare different dance experiences in different cultural contexts and settings. The categorical-content reading (Lieblich 1999) of the transcript interviews supported our hypothesis about the health-related contents of dance (see Appendix).

Dance with drugs

Music and styled youth cultures are collective expressions of generations. The lifestyles surrounding these dances can be niches in which drugs are consumed. The leisure rituals attached to different subcultural groups carry risks of drug use, or dependence on other forms of coping distortions such as plug in drugs among those who seek adventure at home, thus developing dependence on electronic or video games, and video screens. The health risks of drug abuse and lifestyles, which lack essential body training, are obvious and well documented. It is important to consider whether these dance and music centred lifestyles offer protection from these health risks, or whether they generate other risks as well.

Some forms of trance or drug use often accompany ritual forms of dances. In this sense, the dance fashions of the sixties showed neo-primitive features. Psychedelic drugs like LSD, or mood modifiers like marijuana, came into fashion in the sixties and were used during dancing activities.

Our subject can be classified as one of the music and style centred youth cultures attached to given social spaces (Bennett 2000). We may compare the so called *táncház* (Dance House) movement and the salsa dance fashion to other «music and dance worlds» such as the set dance revival (O'Connor 1997) or contemporary dance (Finnegan 1989) in lifestyle frameworks containing health issue features.

In Hungarian youth subcultures, shaped and differentiated by the music they select, drugs of some kind are not rare even among secondary-school students. Magda Szapu (2000) conducted research at schools in Kaposvár, and she differentiated seven music based subcultures: rock based groups like skins, metal rockers, rappers, punks, disco fans, ravers, and house fans. The dance of each of these groups has something common with that of the others.

As Ward (1993) describes, these dances have lost their couple pattern. The traditional grammar of dance-language has vanished. It started with the mods in the late 1960s, but the same features are also typical of the punks, skinheads, and heavy metal rockers. Taylor writes: «Skinheads are great dancers… but never with a girl, always either alone or with other skins.»

The heavy metal "idiot dancers" always dance together; punk dancer couples are the same sex without physical contact (Ward 1993). The techno and acid rave dances are solitary or which is the same thing mass group dancing forms. In disco dancing, neither sex is required to guide the other in a specific sequence of steps.

Magda Szapu has explored some of the differences in drug use among these groups. Skins refuse drugs that cause addiction, but use alcohol (beer) for mood modifying. Rockers accept the use of marijuana, while punks inhale cheap organic solvents. In the subcultures based on pop music, it is striking that girls are heavy alcohol consumers, something which induces more explicit, challenging sexual behaviour. The rappers imitate the Harlem ghetto lifestyle, and use drugs and alcohol. The techno rave orientation is accompanied by the use of Ecstasy. Speed drugs are always available on the market. The source of drugs is mainly The Netherlands and the subcultural drug dealers work in wide networks. The subculture based on the "house" style is thought to be the most exclusive; among its members, it is not rare to use cocaine. It is very interesting that although there are two professional folk dance groups in the town (the Kapos and the Somogy dance group), they were unable to form a working *táncház* in the schools of Kaposvár.

An issue of class gender, education, income, and civic status influence lifestyles, but the orientation towards entertainment seems to be determining. The audience for acid rave techno music acquired the title "chemical generation", signifying a more contested uses of drugs. As Bennett writes: «The ensuing association of house music with Ecstasy resulted in the coining of the term acid house by media journalists who immediately saw comparisons with the psychedelic movement» (Bennett 2000). As mentioned in Szapu's research, this techno house, DJ-based music and dance music reached Hungarian youth cultures in the 1990s.

The acid rave dance and the house culture create a sharp contrast, a counter-culture compared with the practice of the *táncház* (dance-house) folk revival movement. The typology of ravers includes high-tech dependence, use of Ecstasy, altered states of consciousness, "being on the edge", free-style undifferentiated dance, cult of madness and cyborgian, and undifferentiated mass like sociality instead of couple relationships. On the other hand, according to our interviews, the *dancehousers* prefer "natural", folk fashion clothing; traditional structured couple of dances and men's dances, rejection of drugs, heterosexual couple of relationships, and a small-scale social setting. The *táncház* movement has some similarities with the almost 20-year old movement for revitalized Irish rural dances, which resemble set dances (O'Connor 1997). We will explore how revitalisers of the tradition have hidden access to the psychological help and bodily support offered by revitalised culture as a homeostatic system.

«To fly with easy body to the Promised Land without dying»
Dance as drug: addiction to salsa and csárdás

The Guarani Indians describe dance as flying to the Promised Land. It is an expression of the altered state of consciousness induced by dance.

Even dance without drugs can be a means of achieving a trance, promoting dissociation and causing a pleasant experience leading to autohypnosis and ecstasy (Lange 1975). The experience of shamans in ritual dances is usually exaggerated by the use of drugs or psychedelic substances, such as peyotl among Mexican Indians and some of the North Asian peoples (Rouhier 1927).

Salsa is part of the global dance culture as a kind of antithesis to the less structured, individual dances. Salsa is a sort of lingua franca in Central America, as a Caribbean dance of Cuban origin, while Costa Rica's national dance is the *merengue*. Most of the Costa Rican youth do learn salsa, one-third in dance schools, the others through imitation and collective learning. The basis of salsa clubs is formed by little groups of these trained dancers. Every couple has their own style during the dance. The real dance fanatics dance all night. Those people who join for a few hours are not considered real *salseros*. The organisation of movement is an improvisatory variation of a wide range of rolling and turning with the expressive rhythmical movement of the hips built up on the basic salsa steps.

Elena, a 21-year-old student, talks about the meaning of salsa in her life in San Jose. She goes out with the young manager of a little hotel in the city centre. According to her, *salseros* never use drugs, but salsa may be a drug itself, if somebody takes it in "big-enough" doses. She can dance all night, leave the dance floor and go to work. She considers herself a real salsa addict, but salsa is not only a drug, but also a medicine for her. When she has a bad mood or depressing thoughts, dance can help. Dancing is a real therapy. She can cope with difficulties by dancing, not drinking or smoking. Dancing improves her self-esteem; it is a kind of security and support and of course makes her physically fit as well. When she goes dancing, she forgets about everything.

If she cannot dance, it is a terrible feeling, and she gets desperate. If dance were forbidden she says – she would kill herself. She doesn't like to dance only a few hours, she prefers bigger doses: a whole night. Dance for her is really like sex. After a whole night's dancing, she lies in bed and feels that she is in paradise. She couldn't live without dance, and she thinks it is the same for most young people.

This feeling is not expressed or emphasized in precisely this way by the Oxford students, but they also support the view that salsa is good for the health.

Rebecca, a 19-year-old student says:

> *«You feel quite happy at the end of the dance. Salsa is a nice break from anything academic at all.»*

However, as a non-regular dancer, really a beginner who is not properly fit she feels stiffer than relaxed next morning. If she is not allowed to dance, she soon gets uptight. Marco Antonio, a student from a Latin family background, helped the Japanese dance teacher to teach Salsa. He emphasizes that dance is his life. Salsa is a basic physiological need.

Turning our attention towards the Hungarian folk dances that have been revitalized in the Dance-house movement, we can also hear positive reports about the health maintenance and mood modifier functions of dance. These dances are traditional couple dances in suitable settings with slow and fast forms, a wide range of self-expressivity and a rich communicative "vocabulary".

Even these traditional couple dances can be sources for altering consciousness. Bodo 48, the German male dancer from Hamburg, told me in the Válaszút camp that the "palatkai dances"of the Mezség region could induce a kind of meditative state. These data are supported by other observations that dancing can lead to an altered state of consciousness (with changed physiological patterns in the frequency of brain waves, adrenaline and blood sugar) and hence to altered social action. (Hanna 1987, 1988)

Mónika is a student, aged 21, studying at the Vilmos Apor Catholic Teacher-Training College. The dialogue was recorded at the Válaszút Dance Camp in Transylvania.

> *«If somebody forbade dance, I would certainly die. I can not imagine life without dance,»* she says. *«I can dance a whole night without feeling tired. There must be physiological reasons.»*
>
> *«You can see the healing effect of dance on the smiling, happy faces. The other benefical effect of folk dances is exerted on the posture of the dancers. Their bodies express pride, happiness, and self-esteem. The melancholy is extinguished from their faces and from their bodies when the joy of dancing fills their souls.»*

If dance induces dependence and addiction, it may be called a drug. However, another contributor to the discussion, Barna, points out: «Dance is a drug if water is a drug too. Clean water is a basic need, too, accompanied by dependence.»

It is worth citing some opinions from a focus group session that took place in the Válaszút camp with a Canadian dance group from Calgary consisting of second generation youngsters with a partly Hungarian family background. They hold a "dancehouse" for Hungarian folk dances every second month. They all had the same blue shirt with an amusing inscription with some ironic medical anthropological relevance to it: «Our drinking group has dancing problems.» They revealed the mental health content and the social psychological gains, as these dances can heal alienation and loneliness, stop the feeling of isolation.

One girl in the group said:

> *«I think dance just gives people something else to do instead of – you know – going out with their friends and doing drugs or whatever. It gives you some kind of different togetherness.»*

They consider dance an alternative to drug uses. She describes her dependence with the phrase «*itching to dance*»; when she feels it, she even dances in her kitchen.

Some members of the *Tánckör* agree with the concept that dance shares properties with drugs, too. «*Yes, dance is a drug, and if somebody becomes accustomed to it, and feels what its effect is, she cannot stop.*» However, it is a social drug.

The members of the *Tánckör* use the metaphors «up», «elevate», and «to go upwards to spiritual dimensions». In their judgement the main difference between their kind of dance and disco dance is that disco dance doesn't elevate the soul; rather it pushes it down to selfish narcissistic existence and to the instinctual.

They deny that there is an analogy between house or acid-rave dances and the dance of shamans, because the shaman uses drugs and dance for the sake of the community. They consider house parties to be rather a covert market for drug dealers – the more dancers, the potential consumers. Dance and music may represent the same destructive force. The house or acid-rave dancers – according to the opinion of *táncház* dancers – dance for themselves without seeing, hearing or touching the other person, the partner. These *táncház* fans reject techno music as something, which plays a role in deconstructing the social and spiritual content of the dance, while folk dances elevate and enrich.

Members of the Vadrózsa group consider that learning several Hungarian folk dances is a kind of psychic progress. It is worth citing some opinions from a focus group session with a Canadian dance group from Calgary. They are second-generation youngsters with a partly Hungarian family background made in the Válaszút camp:

> *«You have a motivation there to strive to be better. Therefore, you can improve yourself by coming to a dance camp and learning how to do a specific style better. And I guess it is itself a drug when you strive to do better.»*

There is another psychological aspect of variety. There is a large repertoire of dances. They don't think that drinking and dancing are incompatible. Both drinking and dancing are social things.

Dancing, helping and healing

Dance is a way of communication, which can bridge the borders built up by verbal incongruence. For mentally retarded children and adults, music and dance can offer ways for social integration.

In the Bodajk dance camp run by the Jánosi ensemble, there are whole families. Many children participate in the children's plays in the evening, singing, dancing, and being happy together. One thing is striking: a third of them are mentally retarded; there are autistic children and sick children. Nevertheless, they play together. While the band is performing, a young man plays in line with the musicians. He is retarded too, but plays the same way on his toy violin made by his teacher.

These groups of mentally retarded children from the Martonvásár Institute return year after year to the Bodajk camp. The teacher of the mentally retarded children says:

> *«In the second and third year, the healthy families greeted these children as if they were their very old friends. This was expressed in the children's dance. In the first year these children only danced with each other. However, at the end of the second year they became brave enough to dance with "healthy" children, too. This year as it became obvious in the evening they opted for their healthy friends more frequently. The distance was deconstructed, and the healthy friends began to feel compassionate without feeling sorry for them.*
>
> *The natural music, the rhythm and the pulsating, renewing life of the camp, the plays and the work are very beneficial for these mentally retarded children. What I learn here is really transferable to my work in the Institution.»*

These children learn the elementary forms of working; they like the natural materials. During my fieldwork, I met other experts applying folk dances in their work. Szilvia Szke, mother of two children, attended the Válaszút camp with her sons and her husband, who is a surgeon. She worked as a teacher with mentally retarded children in Tata. Of the 120 pupils more than 10 per cent (15 20 children), mainly girls, attended her fun folk dance programme. The decision to join the programme was either theirs or their parents. At the beginning most of the pupils were 6 8 years old, after 5 years some of them remained faithful to the course, so the number of older pupils grew.

After some years musical skills, singing ability, gestures, posture were examined by tests, which proved that folk dance had an effect on the education of these mentally retarded children. She taught the children plays, games, circle dances with rhymes, and later simple dances, mainly the Dunántúl Jumping Dance (*Ugrós*).

The games and circle dances improved the community; co-operative skills diminished aggression and shyness, improved assertiveness, and enhanced sense of control over personal behaviour. Children with slight retardation responded better.

After some initial resistance to the old-style language, the children were influenced by the texts of the folk songs and began to love their poetry. They sometimes even used the words and idioms.

She thinks that co-operative skills and empathy – as a hidden presence in the dance – developed in some of the retarded children. Obviously – she says – the longer she taught a child, the greater the effect. She is very proud of the fact that after 7 8 years pupils still remembered her dance courses with enthusiasm.

I met Ágnes Tálas in the Kalotaszentkirály (Sincrai) dance camp. She talked about her experience of teaching children's games and folk dances among retarded children. She worked with young children in the School for Mentally Retarded Children at Száraznád street, Budapest, and older children (between 14-20) at the ÉNO (Day School for Retarded Children). As she remembers, the results were excellent. The games and dances were really sources of joy with immediate effect. The teachers of other subjects spoke of the good effect they had on the children's openness and development.

The Calgary Vadrózsa group mentioned their experiences of performing in a hospital setting and in several old folks' homes. They danced in the Alberta children's hospitals, and other such places.

> *«In an old folks home sometimes this is the only excitement they get. This is sad. When we arrive, they are so happy, because they can experience excitement and joy. Sometimes someone comes up to us, saying – as they are Hungarian they used to dance these dances when they were young and they are so happy that we are keeping the tradition alive.*
>
> *When we perform in a hospital, we do the same as we do in an old folk's home. We introduce the dances and do a couple of dances and then take a walk around and talk to the kids in the hospital. You just spend time with them in the costumes. It gives them a chance to see something totally different they've never seen before. Lots of kids are in the hospital because they are very sick, or terminally ill or something like that. So it's very nice for them, it makes them happy.*
>
> *They cannot participate, most of them are in wheelchairs, or some of them are bound to machines. [...] The fact that we are invited back year after year says a lot about the effect. Moreover, we see their smiling faces. The children feel joy.»*

Dance as medicine, dance as therapy

Éva Kun, wife of a member of Muzsikás folk group, mentioned that a decade ago, in Bristol, in an alternative cancer therapy centre some Muzsikás music had been used for the therapy of oncological patients. At that time, Beata Bishop, a Hungarian psychologist, had worked with some of the employees of the centre.

Márta Sebestyén confirmed this when I asked her in London, at her Concert at the Hungarian Cultural Centre in Maiden Lane. Unfortunately when we visited this Bristol Centre we could not find those who had applied folk music in therapy, but on the menu of advised alternative therapies we found advertisements for dance groups and the Biodanca programme as well.

Dance and movement can be used as a medium for diagnosis, treatment and intervention, bridging creative expression with psychological theories. This form of psychotherapy uses movement as the medium of interaction and personality change grounded in the healing processes of dance (Schmais 1985).

According to Chace's definition, dance therapy is «a specific use of rhythmic bodily action employed as a tool in the rehabilitation of patients». The dance therapist combines verbal and non-verbal communication to enable a patient to express feeling, to participate in human relationships, to develop empathy, to increase personal self-esteem, to develop a more realistic concept of his body image, and to achieve some feeling of relaxation and enjoyment (Chace 1975:144). The key in this therapy is that personality is reflected in movement, and the larger one's movement repertoire, the more options individuals will have for coping with their own needs and the demands of the environment (Lewis 1972). The Kerstenberg Movement Profile (KMP) offers a comprehensive tool for movement analysis and diagnosis and treatment planning as it synthesizes non-verbal behaviour with psychological theory and interpretation (Merman 1990). KMP describes an individual's status of developmental functioning, movement preferences, areas of psychological harmony and conflict and ways of relating to others. It is the key for the analytic approach when dealing with human dance and movement.

However, KMP is also a sensitive system of notation, which can describe the non-verbal aspects of human interrelationships.

Hungarian dance therapist, Márta Merényi emphasizes the importance of bodily consciousness, and imaginative kinematic improvisations in the therapeutic process (Merényi 2001). Her explanatory model integrates biopsychophysiological, psychoanalytical and cognitive factors in a psychological framework. The theoretical interest turns towards the transition from the holistic complex, non-verbal experience to the verbal, conscious interpretation. The distortion of space perception may be an important symptom of anxiety, and neurosis, especially in phobic forms. Dance therapy can transform and regulate the client's space experience, which induces the intrapsychic processes as well.

Psychiatrist Éva Madarász, 35, works at St. Imre Hospital, and has had experiences both with folk dances of the *Táncház* movement and dance therapy.

> *«I attended a course called "body-mind centering", a meditative therapeutic method with enhanced interoception, sensing one's body, respiration, body temperature. Based on this you try to express your feelings. Unlike gesture therapy this is a very unstructured, improvisatory thing. There is music, you are given some examples, and then you can do it freely. We worked in groups. With your eyes closed you had to feel how the others moved, it developed a sort of kinesic empathy. But I gave it up after a year, because there was no feedback. After a year I felt lonely, just the opposite to my dance-house experience. In Táncház I felt a sort of "a priori" acceptance.»*
>
> *«It is hard to explain, but from the very beginning you feel you belong to the community, and you can feel the effect of music and dance on many different levels. Visceral, acoustic and social, personal and collective.»*

In Éva's narrative the acceptance of the person and the "we" experience of community feeling gains importance.

> *«This aspect of acceptance is very important in Rogers' psychotherapy, mainly for those who have a basic trauma in their mother-child relationship with deeply anxious contents. These people gain by this community experience of acceptance. It is better for them to strengthen their Self in community experience, and later they may become enough strong to start individual therapy. The Táncház experience offers this. The mind-body centering course had a different logic and I lacked the trust at group level.»*
>
> *«The folk dances are very disciplined emotionally, and rich, just the opposite of the libertine freedom of disco dances. Working up destructive forces, or coping with the aggression, can be preliminary to building up the personality. Folk dances may help in this too. I don't know whether the female dances do it, but the males' dance is an obvious framework for this. Sometimes shouting rhymes and turning around faster and faster can be an outlet for the girls, too.»*
>
> *«The patriarchal asymmetry between genders in folk dances performed in the world of gestures, postures, and choreography may be a source of a hidden need of behaving in traditional ways, which doesn't hurt the everyday constraints and expectations towards dominating gender roles. It can be complimentary or compensatory as well.»*
>
> *«In dance I was not a person to be led, maybe because of my dominant style as a Doctor, or emancipated woman. However, I wanted to be led, to be directed and I was happy to see that it is possible. If it works, it can work in me too. It helped me to be more spontaneous.»*

Generally, folk dances are not part of the circle of dance therapies, although they have therapeutical value. Like the symbolic healing of primitive cultures, folk dance cannot be medicalized easily. For therapeutical use, you must extract the content, like you do with ethnopharmaceuticals.

There is no need for rituals or beliefs, just for chemical content.

Psychiatry uses progressive relaxation, sociodrama, catharsis therapy, and trauma disclosure, encounter training, kinetic elements. Although folk dances provide some of these, they resist medicalization. It seems that medicalisation needs an analytic framework to create an interface between dance and medical explanatory models. KMP does it for dance/movement therapy.

According to Éva Madarász, folk dances *may be part of group psychotherapy, as a complex cultural process in healing groups of drug patients.* There is an exceptional example of healing with folk dances, which proves the value of this suggestion.

Zoltán Pet, head of the Institute of Neuropsychiatric Rehabilitation at Szeged University gives an overview of the healing function of folk dances practised in therapeutic groups of depressive, schizophrenic and other psychiatric patients. The archaic rhythms and elements of the folk dances help to solve psychomotor inhibition and develop communicative skills. Dr. Pet emphasizes the emotional influence and collective functions of folk dances in healing while dance and movement therapy offers rather individual and cognitive means.

Closed, inhibited emotionality can be opened, and emotional resonance can be developed by therapy based on folk dances. Dance therapy enhances the ability of listening, and improves disciplined behaviour. The sociotherapeutic content of folk dance therapy includes effective group forming, the enhancement of the "we" experience. Dance therapy is part of a wider art-therapy based on a folklore heritage that includes weaving, sewing and painting. Some of the patients' artistic products can be seen on the walls of the room that is 10 × 8 meters big. A big three-piece mirror helps to give patients an idea about their own movements and dance skills. The dance session is scheduled on Tuesdays, Thursdays and Fridays from 11 to 12 am. Participation is not compulsory, but every participant is involved in common dance. The number of patients varies from 12 to 25.

The session starts with relaxing gymnastics and attainment to the music. As Edith, the dance therapist describes the patients dance in circles. It is impressive how blind patients happily dance with the others. Marika, a patient suffering from deep major depression, showed elementary response to dance therapy. She sat for a little while, then joined the circle. Her transformation was striking. She said at the end of the session. I haven't listened to music for a long time but now that it has come to my ears, I can hear it again. The whole group showed compassionate joy when they heard

Marika's words. The patients have proved the effectivity of folk dance therapy, because it has now been practised for more than six years.

Concluding remarks

Exploring the narratives of our informants, we can reveal the role of dance in creating better mood, joy, fitness, better living and social support, all of which are health promoters. On the other hand, some forms of dance are attached to special lifestyles and distortions like drug use, smoking and drinking and may be clustered in some youth subcultures.

The embodied and lived culture mediated by dancing creates movement communities that are not bounded to their language-limited communities. The transcultural attraction of these dances can be discussed because of their adaptive value. The cultural experiences of gender, community, health, coping with stress and emotional strains and way of life, all embodied in folk dances and in salsa, may gain medical anthropological significance.

Dance is a way of expression, self-experience and communication, which can bridge the Cartesian gap between embodied and logocentric representation of the social and cultural environment, and offer insight with healing potential.

Although folk and popular dances have health-related importance, they are not generally part of dance therapy because there is no analytic theoretical interface with biomedicine unlike mind/body centering, or dance and movement therapy. These dance therapies have their background in psychoanalytic developmental theory, and have a diagnostic/analytic tool in the Kerstenberg Movement Profile. Cognitive theory and psychophysiological frameworks may be integrated into this approach too. The psychophysiological, etic analysis of contemporary or traditional couple dances may substitute these missing theoretical elements. The social and cognitive psychological aspects offer further insight.

The personal experiences and the exceptional therapeutic use of folk dances described above prove the health-related effects and the medical applicability of couple dances. The medical anthropological approach can explore the process of medicalising cultural topics like dance, on the one hand, and help bring dance closer to medical discourse, on the other.

Appendix

Narrative analysis in categorical-content perspective

Health-related cluster

Principal sentences	*Category*	Comments
«In song it's not the voice but the soul that stretches its limbs.»	*emotional outlet*	the singer is conscious of the psychic functions of singing
«Under the beautiful sweeps of song tension, we don't feel that the soul is struggling, that singing is coping but that the heart is growing lighter and freer.»	*release*	consciousness of choice
«With these songs it's not tradition that we cultivate, but ourselves.»	*not only cultural, but psychic needs*	consciousness of self-help increases during singing
«Music and song were not just aesthetic values, but human and even bodily values too.»	*embodiment of culture*	Kodály expressed his experiences while he collected folk songs
«Why did God give melody and song to Man? To put us in a good mood and not to be sad. Because if we're sad nothing will come of it, we may just fall ill.»	*emotional coping*	implies tacit knowledge
«I sing more in my grief than in my joy.»	*emotional coping*	self reflexivity regarding coping
«People sing to push their sorrow away.»	*emotional coping*	
«Song: I forget sorrow and fill my heart with joy. I fall into a dance and cry out in happiness.»	*emotional expression*	
«Song is love of the soul. Song is like a health tonic.»	*emotional coping*	
«Singing is a comfort to the body.»	*self-regulation*	expressions of bodily experience
«You open your mouth, lift up your hands, and tell of your life in song.»	*trauma disclosure*	realised connections between life events and expressions
«Dance helps to release of tensions.»	*Release of tension*	
«It is a source of joy and good moods, which itself is a health promoter.»	*mood modifier*	
«Experiencing destructive force, or coping with aggression can be preliminary to building up personality. Folk dances may help in this too.»	*coping with aggression*	psychiatric aspects of dance expressive behaviour
«It is recreation in the noblest sense. Recreation sounds like games and sports, but this elevates us more.»	*recreation*	

Segue

Gender-related cluster

Principal sentences	*Category*	Comments
«But soon I realised that in these groups the men were more man-like and the girls more girl-like.»	*socialisation of gender roles*	contesting traditional gender roles
«It is the experience of being a woman 100 years ago.»	*tension between changes in gender roles of society and tradition*	awareness of conflict
«Dancing folk dances was very important to become a woman. I started to feel the real meaning of being a woman after experiencing it in dance relationships.»	*socialisation of gender roles*	Implicit contest of traditional femininity
«These roles are still not deconstructed. It is clear what the task of a boy is and what task of a girl is, what is playful, serious or enriching.»	*socialisation of gender roles*	contested patriarchal conservativeness regarding gender roles

Ethnicity-related cluster

Principal sentences	*Category*	Comments
«The táncház dances made me really Hungarian»	*dancing and singing as creators of identity*	Ethnic socialisation
«We'll be Hungarian as long as we sing and dance Hungarian»		Dance as therapy for cultural bereavement

Drug-related cluster

Principal sentences	*Category*	Comments
«My wife said that mez? ségi dances may induce a kind of meditative state.»	*dance as inducer of ASC*	
«Dance is a drug if water is a drug too. Both create dependence.»	*dance as a vital need*	denying the drug role of dance
«Yes, dance is a drug, and if somebody becomes accustomed to it, and feels what its effect is, she cannot stop.»	*quasi-drug effect of dance*	acceptance of the metaphor regarding the drug role of dance
«Salseros never use drugs, but salsa may be a drug itself.»		

Therapy-related cluster

Principal sentences	*Category*	Comments
«The natural music, rhythm and the pulsating, renewing life of the camp, the plays and the work are very beneficial for these mentally retarded children.»	*therapy of mentally retarded children*	pedagogy as therapy
«Rural work exhausted the people physically in a way which had to balanced by another physical activity.»	*physiotherapy*	extended view of therapy
«Working curved the countryman's spine, dance straightened it out.»		

Segue

Principal sentences	***Category***	**Comments**
«Moving heals problems caused by other kinds of moving, just as in medicine, where the stiff parts of the body are healed by physiotherapy.»		
«A lot of kids are in the hospital because they are very sick, or terminally ill or something like that. So it's very nice for them, it makes them happy. »	*mood modifier role of dance as healing*	
«When drug patients need a whole cultural alternative, folk dances can heal.»	*dance as cultural therapy*	

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Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 373-391

Prescription of antidepressant medication by general practitioners: total social reality?

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We shall discuss what anthropology brings to the analysis of certain problems that are currently treated medically.

Precisely because medical issues are necessarily broached by many other disciplines, we feel that anthropology is situated at the vanguard of many questions, and is obliged to redefine its objects and demonstrate the heuristic value of its approach. In this undertaking, medical anthropology, which has often borrowed from various theoretical currents, puts the whole of anthropology to the test unless it seeks to define its originality from within.

Here we will outline only a partial and empirical illustration of this vast project, by analysing general practitioners' discourse about their practices in terms of prescriptions and treatment for with patients that describe themselves, or that the physicians diagnose, as being depressive.

1. French epidemiological data on depression in general. medical practice and issues

The "depression" that has been largely examined by Anglo-Saxon anthropologists (Kleinman 1986; Kleinman and Good 1985) is estimated to be the second-ranking cause of invalidity, according to the World Health Organisation. According to Ehrenberg, depression in France has become «our main form of intimate unhappiness» (Ehrenberg 1998). In the psychiatry of the early 20th century, depression was one symptom associated to others but has now come to constitute a separate pathology that can be apprehended without theory, which is subject to symptomatic diagnosis and which non-specialist physicians can establish using the appropriate manuals (DSM

IV, CIM 10). But the pathological entity called "depression" as it is manipulated in practice by general practitioners, and even more so the popular entities loosely differentiated in France under the headings "*dépression*" and "*déprime*", do not correspond exactly to the set of symptoms listed under this designation in diagnostic handbooks. Epidemiological surveys like the one published in 1999 by CREDES must use tools to reveal the existence of these afflictions, independently of spontaneous declarations. In this case it was the *Mini International Neuropsychiatric Interview* (MINI). It is now proposed to furnish general practitioners with this type of tool in order to diagnose and treat major depressive episodes that would otherwise go unnoticed (4). In the CREDES survey, the rate of 6.3% of individuals declared to be depressive rose to 12% with the MINI questionnaire alone. Earlier surveys by the same organisation (1994), however, underscored that consumption of antidepressant medication was two to four times higher than in neighbouring countries. This means that the 1999 results concluding that the French population is insufficiently treated are something of a paradox. The majority of these afflictions are treated by general practitioners, just as they see 11% of their patients for "life events" (Pouchain *et al.*, 1966), so we realise that a good share of what in our society is called the "depression" syndrome is handled during office visits to general practitioners.

We observe a significant increase in cases of depression reported over the last 30 years. In surveys on health and medical care in France four times as many people claimed to be depressive between 1970 and 1980, and seven times as many between 1980 and 1996. The epidemiological data cited show that «all things being equal», «situations of unemployment, divorce, living alone are highly associated with risk of depression» (*op. cit.*, 1999). This type of morbidity can be understood in two ways. There is a growing medicalisation of the «pain of being» (Jaeger, 1998), just as much as an embodiment of social suffering and inequalities, insofar as management level employees, and those exercising higher intellectual occupations (men and women), and farmers (women) «seem to be protected from the most active forms of this pathology», even though paradoxically «they declare it more frequently» (*op. cit.*, 1999). Biological models of depression describe it as being a deregulation of cerebral neuromodulation systems, or of the biological mechanisms that allow the individual to adapt to the environment. So, we are confronted with a type of reality «in which the social nature is very directly connected to the biological nature of man» (Mauss 1926). The author continued: «In addition, these facts are also "total" facts that I believe merit study. Consideration of the psychic realm, or better still of the psycho-organic realm is not enough to describe the entire complexes. The social sphere must be taken into consideration. Inversely the study of just the fragment of our lives constituted by life in society is not sufficient.» So we can see more precisely how Durkheim's "*homo duplex*" is situated, and how this "double nature" can be contemplated.

We will touch upon only one of the facets of this task, but one that in our view is revealing of the perception that the main actors – the general practitioners – have of the nature of the reality they have to treat.

2. *Survey and methodology*

The subject emerged from the peculiar turn taken by our study (funded by MILDT) of the "differentiated management of dependencies by general practitioners" in the region of France which, on an epidemiological level, is known as one of the most heavily areas affected by alcoholism (5) and suicide among the young (6). The instructions were to place each patient's visit during one day within the history of the therapeutic relationship, specifically mentioning all known problems of dependence. This interview was recorded in full and transcribed for analysis. The day of the interview was chosen from the days of the preceding week of activity. In this week the practitioners had been asked to note, the reasons for each patient's visit their diagnoses and prescriptions. In this way, we would have an idea of the practice and clientele of each practitioner. The interviews were carried out using charts to summarize the practitioner's present activity. The comments were an account. We interviewed 10 general practitioners in the region. Five belong to a private practice/hospital network for treating addicts. The other five are practitioners who work in residencies, taking in residents for periods of 3 to 6 months a year (7). For the purposes of analysis, the interviews had to be anonymous so the authors who also participated in teaching and training activities interviewed the subjects. Practitioners are credited with a minimum of current knowledge concerning psychotropic substances (Tamblyn *et al.*, 1996). For the group of practitioners that includes residents, it goes without saying that they teach, and therefore know, the most recent recommendations made by the accepted conferences in the field. This only makes the following discussion all the more pertinent. The survey was completed with five more practitioners, chosen at random this time. As the interview was to last no more than two hours, we restricted ourselves to one day. However, our first practitioner was not satisfied with the day he was asked to comment upon, and he made a point of telling us, in addition, about all the patients he had seen in the week, who in his view were interesting for our inquiry. We then suggested to the next physicians to do the same. We thus have interviews in two parts, one day totally covered (whatever the pathology of the patient was) and an overview of the other days of the week in relation to "dependences". It is remarkable that the physicians chose to tell us about a great many visits that did not refer to past or present dependencies, but to "psy" problems in the expression of one respondent (8). In these cases, suffering was expressed by functional disorders, or by psychiatric disturbances. They fell into the category of antidepressant treatment, harking back to depression or "depressive states", which the physicians sometimes refused to medicalise as such. These problems run through the entire corpus and are very rich in information about the physicians' practices. For this communication, we have taken extracts dealing with depression or the prescription of antidepressants (9).

By analysing the practices of the physicians in both groups, we can compare their prescriptions of antidepressants with data gathered in studies of populations who consult general practitioners. According to a 1996 WHO study cited in Le Pen (Le Pen 1998), 10.4% of patients were diagnosed as depressive, whereas this figure rises to 13.7% of the population at the Parisian centre of this study. Our physicians in the first group, all practising in cities, prescribe an antidepressant every 14.7 visits of to patients aged 15 and older (6.77%). The physicians in the second group, practising in towns or in the country, prescribe an antidepressant every 9 visits of patients' aged 15 and older (9%). Diagnoses, including Manic-Depressive Psychosis (MDP) and anxiety-depressive syndromes, are 5.7% and 9.5%, for patients aged 15 and older, respectively. Indeed antidepressants are prescribed for disorders such as alcoholism, or for "senile dementia" (10). While some of these prescriptions do not correspond to the diagnosis of depression, this diagnosis does not always result in a prescription.

In the survey, in which no models or diagnostic criteria whatsoever for depression were asked for, this disorder is most often evoked in the life history, in a family or social context known to the practitioner through various sources. The practices of these practitioners, as reported, appear to run counter to the hegemony of symptomatic diagnosis. Indeed, if for the reasons given above we exclude a lack of information that is assumed by MINI proponents, then the experience that these physicians have reconstructed of their encounters with patients whose suffering is qualified as depression must refer to something else. This is exactly what we will attempt to analyse by studying in detail what the prescription or non-prescription of antidepressants refers to.

3. The diagnosis of "depression" as related in interviews with general practitioners

In the comments about visits that we have gathered, there is little mention of the search for symptoms. When insomnia or other symptoms are referred to as such, it is often a confirmation (we would say a rationalisation) or an answer to a question from the investigator, as in the following example:

> Q – *«mais quand elle est venue là pour sa dépression, elle est venue en disant qu'elle faisait une dépression ou c'est vous qui l'avez diagnostiqué ? Comment ça s'est passé ?»*
>
> M – *«'ben' elle est venue en pleurant»*
>
> Q – *«ah elle est arrivée en pleurant»*
>
> M – *«elle est venue en pleurant en disant que ça allait pas du tout et elle m'a pas demandé qu'est-ce qui lui arrivait mais elle est venue en me disant ce qu'elle avait et qu'elle le vivait très mal et donc le diagnostic de dépress d'état dépressif réactionnel a 'quand même' été posé sur les troubles du sommeil et y'avait pas de troubles physiques mais y'avait un manque de goût à tout ce qu'elle faisait enfin bon etc. hein c'est comme ça que le diagnostic a été posé. Mais y'avait une demande, y'avait une demande hein.»* (733) (11)

The massive obviousness of the «well» («*ben*») commenting the reality of crying precedes the confirmation «even so» («*quand même*») by the «sleep problems.»

Depending on his or her personality, the physician "rationalises" to a greater or lesser extent. These elements are never presented as the initial analysis. They emerge to support a feeling based on a perception of the patient's life experience and on the knowledge of the patient's history.

> *«... et il est dépressif, pour moi il est dépressif »* (12)
>
> Q – *« il a des insomnies, il a... ?»*
>
> M – *«il se réveille fatigué, il est fatigué toute la journée, il a mal partout, il a envie de rien faire, il a pas envie de lire. Il a les signes cardinaux de la dépression.»* (13)

Clearly the physician masters these technical terms and will use them later:

> *«manque peut-être, peut-être l'insomnie du matin hein et encore je crois qu'il se réveille assez tôt, mais ce qui domine surtout ce sont les troubles somatiques, l'anhédonie et la fatigue hein ça c'est les trois tableaux»* (14).

However, in most instances the mirroring discourse of the patient clearly shows that we are dealing with the proximity of empathy, and not with the distance of diagnosis of symptoms.

Some physicians told us about their clinical criteria. Nevertheless, this is not the case in the majority of comments where the diagnosis appears to be built on the physician's feeling about the patient's mood.

> *«c'est une petite dame qui n'est jamais bien dans sa peau… J'arrive à ce qu'elle ressorte d'ici avec le sourire alors qu'elle est rentrée toujours très triste»* (682) (15).

This state is linked to known events in the patient's life:

> *«Bon c'est un très vieux monsieur de 83 ans qui a toujours été un peu dépressif. C'est moi qui l'ai mis aux antidépresseur y'a 16 ou 17 ans quand je suis arrivé ici, parce que lui et sa femme étaient bien tristes. Ils venaient d'arriver en retraite et ils étaient bien tristes tous les deux.»(870)* (16)

> *«C'était un monsieur qui était fermé parce qu'il était dépressif, dépressif parce qu'à son boulot on veut le virer» (343)* (17)

Or more serious still:

> *«Elle prend depuis la mort de son fils qui a été longtemps malade avant de mourir enfin pendant un an elle a il a été assez malade et puis il a été suivi après si tu veux il a été dans un coma pendant presque trois mois enfin ça a été très très pénible pour elle et depuis un prend un antidépresseur»* (728) (18).

Yet again:

> *«C'est une dame que je connais très bien, qui, que j'ai eu quand je l'ai connue y'a vingt ans, elle était je dirais alcoolique mondaine, femme de notable, s'ennuyant un peu toute seule, consommation d'alcool largement supérieure à ce qu'on peut admettre. Son fils s'est tué en voiture, ce qui n'a pas arrangé les choses [...] je pense que maintenant elle ne boit plus, elle ne fume plus, bon ça ça date de dix douze ans hein, mais par contre elle a ce fond dépressif auquel moi j'associe la consommation d'alcool, ce fond dépressif ressort de manière cyclique, donc là je l'avais, au début de l'année je l'avais mis sous Deroxat* et ça c'est bien passé, elle était plutôt positive»* (693) (19).

We become aware that the general practitioner, who has the qualification of family doctor, reacts to all that s/he grasps of the patient's history, through all that has been said in consultation naturally, but also through things learned by participating in the social life of the neighbourhood or town.

> *«Lorsque son mari est décédé elle était très triste apparemment mais en fait elle a commencé à dépenser de manière compulsive tout ce qu'ils avaient mis de côté et donc j'ai eu l'occasion de la voir chez elle et je lui ai posé la question à plusieurs reprises hein et je lui disais que si, elle était très triste bien sûr par rapport aux événements mais que sans doute si elle avait tendance à abuser un peu des des apéritifs le soir notamment, bon c'est à cause de la solitude, le lendemain matin elle devait être encore plus triste quoi, et là, à chaque fois elle minimisait alors que les voisins me disaient qu'elle débarquait à 22 heures 23 heures dans un état qui laissait pas de doute hein.»* (678) (20)

Likewise, very few semiological elements are given with reference to manic-depressive psychosis (MDP). The utilisation of this concept by general practitioners turns it into an entity for psychiatric treatment, which they cannot get a grip on. Some of the prescriptions for antidepressants (15 out of the whole corpus) are repetitions of treatments started during psychiatric hospitalisation or prescribed by a specialist. The hospitalisation reports, which sometimes present different diagnoses for the same patient, including diagnosis of MDP (155), do not give them much help. In the prognosis, it emerges that this entity, more than depression, belongs to the register of "psychosis" in the sense of a "very serious" illness requiring periodic hospitalisation (716) in a familial context that is sometimes tragic, such as those of the manic depressive *«qui a pété les plombs, dont l'oncle s'était pendu»* (who went off his rocker, the uncle hanged himself). Looking at the succession of psychiatric diagnoses, it seems that general practitioners prefer that of MDP, perhaps because it is less of a stigma for the patient, if it is presented as a sort of depression, and treated with antidepressants, among other medication. Nonetheless, like other psychiatric entities, it reveals the gravity of the disturbance and the inability to resolve it (806), the character of chronic illness that antidepressants regulate without hope of a cure.

> *«Elle a un fils qui a, qui est très dépressif un petit peu, un petit peu maniaco-dépressif, célibataire à plus de 60 ans aussi enfin»* (844) (21)

In general, in practitioners' practice related to "psychiatric" afflictions, it seems that the diagnosis is confirmed by the efficacy of the product administered, in this case a neuroleptic:

> *«Alors là pff j'en sais rien, c'est une dame, une psy d'un grave, bon elle prend des médicaments pour dormir aussi. Mais elle est psy hein, moi j'ai marqué paranoïa sensitive, ça c'est c'est moi qui fait ce genre de diagnostic mais, dans le sens où elle est elle est toujours en train de pleurer, elle a, toujours en train de se plaindre, elle, elle parle en pleurant, sans larme tu vois? donc elle a vraiment un problème, et et d'après ses enfants, elle est quand même mieux depuis qu'elle est sous Tercian*, ça l'a un petit peu enfin (?), bon ben elle a pas eu de chance non plus hein elle a elle a eu un ou deux de ses enfants qui sont morts jeunes»* (844) (22).

However, the comment that ends the presentation of this case shows that the physician finds it hard not to read some meaning into suffering treated in this way.

4. *Prescription of antidepressant medication*

Not all sadness lends itself to treatment, however, and some states, such as bereavement, are left to take their natural course *«Donc sur son problème de tristesse on a discuté, mais y'a pas eu de traitement»* (So we talked about her problem of sadness, but there wasn't any treatment). This was also the case of a female patient whose husband had abandoned her upon learning of her breast cancer and who was «not feeling well», *«n'est pas bien dans sa* *peau»*. She came to talk to the physician. Yet this is a case where prescription would be possible, for the general practitioner concludes: *«pour l'instant' il n'y a pas de traitement»* (for the time being there is no treatment). In these cases, some physicians give *«Guronsan® et puis des Oligosols® pour éviter des antidépresseurs ou des trucs comme ça, avec des bonnes paroles. Sans compter que la visite a duré au moins une heure...»* (Guronsan® and then Oligosols® to avoid antidepressants and things like that, with some good words. Not to mention that the visit lasted at least an hour). They gave their time. They also give their energy *«en fait elle avait une grosse inhibition anxieuse, mal de chien à lui arracher trois mots»* (in fact she had a major anxious inhibition, and I had a tough time getting three words out of her).

An extremely bad family situation requiring antidepressants (see below), such as the possible rape of a child, or the situation of a young woman who is described as «completely stressed out, she was off her rocker» (*complètement stressé, elle pétait les plomb),* were "treated" by prescriptions for an anxiolytic. The physician who had asked whether this woman felt suicidal (*si elle avait des idées suicidaire),* received the reply that she felt more like running away abroad. Likewise, the grief of bereavement that the patient drowns in a frenzy of compulsive purchases and alcohol is not even treated with medication, like the grief of a woman who at age 86 had lost her husband:

> *«qui a perdu son mari et qui s'en sort toute seule ... c'est assez rare en général, la plupart des personnes âgées sont souvent sous anxiolytiques, antidépresseurs en ce qui les concernent ... elle avait largement de quoi s'en sortir toute seule»* (23)

In all these situations, treatment involving psychotropic medication is not similar to other circumstances.

Antidepressants are prescribed when the disturbances are qualified as "psychosomatic", manifestations of a non-verbalised suffering that the physician tries to understand.

> *«On a beau se dire que c'est une colopathie. Bon. C'est psychosomatique mais est-ce vraiment psychosomatique en même temps, hein? c'est, on est on est dans. D'un autre côté, des examens Dieu sait qu'elle en a eu, alors est-ce qu'il faut aller encore plus loin? Je sais pas ... Là je suis un petit peu emmerdé, parce que je je comprends pas trop non plus quoi, je comprends pas trop pourquoi maintenant. Mais en même temps, en même temp, c'est peut-être parce que y'a une souffrance qui qui qui qu'on comprend pas et qu'on touche pas et, bon on va voir hein. Et donc elle, sur le plan médicament, / cette femme n'a jamais eu de traitement psychotrope, pour autant que je me souvienn ... Ça c'est un truc , problématique, qui va poser des problèmes, qui est pas résolu, je suis même pas certain que ça sera résolu un jour.»* (142) (24)

If the antidepressant mitigates the disturbance or if stopping the medication worsens the symptoms, then the diagnostic is confirmed. As in the case of a man who had a stomach ache every time he had worries, *«mal au* *ventre chaque fois qu'il avait des soucis»* and for whom the antidepressant was effective, *«c'était donc bien un syndrome anxio-dépressif»* (25) (808) or a widow whose digestion problems are attributed to grief, *«c'était vraiment psychosomatique complet»* (26) (542), because they start up again when treatment is stopped. But for some doctors the relevance of this type of treatment seems to be like a step towards achieving verbalisation. For example, an elderly woman was treated for stomach troubles. The doctor said: *«Donc je lui avais mis un antidépresseur qui marchait bien»* (27), which the patient welcomed, *«tous les mois ou les deux mois je la vois avec les même doléances, donc je l'écoute et lui renouvelle son traitement de façon à changer»* (28)*... «bon, elle vient se plaindre, vider son sac un petit peu j'ai l'impression»* (29). In more severe cases, like fibromyalgia, which resists treatment with antidepressants, the same physician is at a loss, convinced that the woman's extremely reserved attitude hides a secret that the pain irradiates. However, he is unable to make her talk;

> *«si j'essaie de lui suggérer qu'elle a des soucis qui pourraient ... pof, le blocage tout de suite, donc , j'arrive à rien avec elle ... Donc je pense qu'il y a quelque chose derrière dont elle ne veut pas parler, consciemment ou inconsciemment»* (30)

Backgrounds of alcoholism, prevalent in certain neighbourhoods, are sometimes associated with a tendency to depression, "*un fond dépressif*", and encourage this recourse.

> *«... ça c'est un grave, un grave aussi, c'est un diabétique qui a un comportement très très compulsif, avec ee des cuites phénoménales, qui ferme quelques fois la porte aux infirmiers, je je quasiment suicidaire, quasiment suicidaire ..., il est très agressif... Donc il a fait également un infarctus, il est sous Effexor ... voilà»* (31)

5. *Effects of treatment*

The pertinence of the prescription and the effects of treatment are reinterpreted, or at least related, in the same framework as the diagnosis. It is not easy to give an account of how treatment is experienced. The comments are repeated, briefly, but no details of the resolution of symptoms are given: *«il est sous antidépresseur et ça lui va bien, voilà.»* (32) *«elle est correcte voilà»* (33) *«c'est vraiment le médicament qu'il lui fallait, et elle est d'ailleurs sensiblement mieux»* (34) *«finalement elle a trouvé que c'était pas mal»* (35) *«ça semblait être un peu mieux»* (36) *«il a l'air d'avoir retrouvé le moral»* (37). Concluding their accounts of office visits, the general practitioners position themselves more in the register of overall care for the person, than in the register of curing the disease. This is supported by expressions such as *«je voudrais l'aider mais à mon avis pour l'instant, 'je ne la tiens pas' quoi, je ne la tiens pas»* (38) or *« 'contact' très* *intéressant, on cause bien ensemble»* (39) evoked by the same physician referring to another patient. Another doctor theorises this for his practice, *«J'essaie d'avoir une relation très proche avec le patient, si je le connais trop, je l'envoie chez un psychiatre»* (40). The physicians keep the patient away from a possible breakdown (*«effondrement»*) with its recognised fatal risks by staying in contact and maintaining the patient sufficiently within the framework of a therapeutic relationship to achieve this, but at a proper distance; – a symptomatological focus does not suffice for these ends.

These situations in which these family doctors diagnose "depression" show that they attempt to establish a real contact (*«arriver à établir un vrai contact»*) so as to bring out (*«faire exprimer»*) the unspoken that is revealed by the symptoms. The same is true for situations in which they justify prescriptions of antidepressants, whether for "depressions" linked to drug or alcohol abuse, elderly people, the ill, or for any other problem associated with bereavement, work relationships, or antidepressants prescribed in organic affections analysed as somatisation. When the contact has not yet been established with patients whose treatment was started by another doctor the recent nature of the relationship is put forward as the explanation:

> *«Et alors, bon alors en plus, mais j'ai pas trop creusé parce que malheureusement normalement, c'est vrai quand je les vois pour la première fois, je prends plus de temps et puis là c'était un peu sur le fil donc j'ai pas pu, mais on va se revoir, on va en parler ... et puis visiblement le (praticien de médecine douce) qui la suit il l'a mise sous Séropram* et Lexomil* depuis peu de temps et que, mais ça j'ai pas trop fouillé, savoir quel était la raison de son état dépressif alors qu'elle est amoureuse, m'enfin bon. Donc voilà».* (41)

There may or may not be a "reason" and if it is hidden, the antidepressant can help «to get things moving», *«ce qu'au moins quelque chose bouge»*.

Through their experience these physicians are well aware that sometimes those that they readily qualify as "true depressives"– because they do not know the "reason" for their illness, or do not believe in the socially acceptable reason that is advanced- might collapse and reveal tragic family histories. For instance, a young mother, who seemed to have no real problems until she collapsed sobbing and spoke of a deep conflict between brother and sister, and their mother,

> *«sans soucis a priori, sauf que en grattant un peu ... était venue pour trois fois rien, on commence à parler ... s'effondre brutalement. Vraiment j'étais sidéré, et en fait elle me parle d'une histoire familiale, gros conflit entre frère et soeur et la mère ... dans un sanglot permanent»* (42)

She did not, however, reveal the underlying problem (*«le fond du problème»*). Likewise, the third depression of a young woman, related to work difficulties (job loss), *«un problème de travail, elle avait perdu son poste»*, reactivates the circumstances that had led her to consult the doctor at an earlier time, after the suicide of her father who was known to be an exhibitionist. The discussion turns to worries about the anorexic granddaughter. The palpable unspoken side of this family does not respond to attempts at psychotherapy, which are rapidly abandoned. Sometimes a patient recognises only sleep problems, and an antidepressant is given as a substitute for hypnotics, to try and "unblock" the situation, as in the following unsuccessful case:

> *«alors ça c'est un type qui est très très introverti, y'a de très gros problèmes de couple dont il n'arrive absolument pas à parler. Ça c'est la femme qui m'a dit hein?(RIRES) / il a eu des épisodes, il a encore, j'crois c'est un type qui profondément est dépressif. / mais qui n'arrive pas à exprimer quoi que ce soit. Sa femme m'a dit, qu'il il avait eu des pulsions suicidaires. J'en ai parlé avec lui mais il n'a jamais reconnu. / il a eu des troubles du sommeil, un mauvais sommeil qui était très très important, il ne dormait plus du tout, il/, mais bon il n'a jamais voulu, je n'ai jamais réussi à le f..., enfin il n'a jamais réussi à exprimer quoi que ce soit, il a toujours refusé de se faire aider, que ce soit par / par moi ou par un/, un un thérapeute, la seule chose qu'il acceptait un moment donné, parce que bon il voulait dormir et moi je lui ai dit écoutez, les troubles du sommeil sont liés vraisemblablement à une dépression, je ne vous donnerai pas d'hypnotique, et puisque bon, la situation était bloquée, je veux bien vous donner un antidépresseur pour voir et puis après si ça débloque la situation on pourra peut-être en reparler, parce qu'évidemment il a mieux, mais il n'est pas allé plus loin, et, et, il a arrêté au bout de deux mois, deux trois mois, et puis, . Alors je le voyais régulièrement tous les quinze jours, mais ça, c'est un mur, quoi. Il disait oui ça va mieux, je dors mieux. Bon ben alors / ben rien. Et puis voilà. La vie a continué, il prend pas de médicament mais / il est pas bien, sa femme non plus d'ailleurs.»* (43)

For the physician as well as for the patient, the illness "depression" is a «syndrome of signification and experience» (Good, 1998); together they seek to "encircle" in order to contain it. In our view this is how the term "reason" should be understood. Rather than sticking to a «linear causality» (Dardennes, 1999), for the physician, it could be a question of finding a meaning, an intelligibility, perhaps fictive but operational, that gives the doctor the capacity to initiate and support the care process for the patient.

6. *Social suffering thus embodied*

For the general practitioners in our study, the depressive episodes take place in a context that gives them meaning; a familial, social, even political context related in the interviews, rather than the symptomology of depression. By reflecting the closeness that they seek to have with their patients, their discourse unfolds the manifestations of social suffering, as seen by the patients.

They naturally mention bereavement and separation, but in contexts that make them more difficult. For example, when a patient requires intensive family care:

> *«elle est dépressive la dame. Elle est dépressive mais elle est dépressive donc elle est sûrement accrochée à son temesta pour dormir, mais bon elle a des raisons hein, elle a elle a sa fille qui est hémiplégique qui vient de débarquer, enfin qui vient, qui est qu'ils ont pris en charge chez eux depuis deux ans et donc, la cohabitation est très difficile et son fils qui est mort subitement cette année, donc elle a un peu des raisons de bouffer du temesta hein. Et du prozac»* (44)

When the absence of a diagnosis makes it hard to accept the death of a spouse, doctors say: *«elle me dit 'je m'en sort pas' ... son mari est mort on n'a jamais su de quoi, même à l'autopsie. C'est difficile à lui expliquer»* (45), the physician eventually suspects new diseases that are not analysed in routine autopsies.

The accumulation of family or marital conflicts and pathological or delinquent behaviour of children exhaust the patient's capacities: *«la mère en a fait une dépression, elle a tenu le coup un certain temps et puis voilà ...»* (46). The antidepressant means an alternative :

> *«traitement antidépresseur parce qu'elle était vraiment pas bien ... maintenant ça va mieux, parce qu'elle a aussi retrouvé une accroche sociale, elle travaille ... le problème du fils n'est pas réglè ... c'est vrai qu'on reparle un peu de tout ça au cours des consultations ...»* (47)

The physician tried to use the same approach to break down a dependence on benzodiazepines that began with a divorce, but the woman absolutely refused to talk about it (48).

As some of the doctors handle substitution treatment for substance-abuse patients (8 out of 10, not necessarily in the private practice/hospital network), personal separations that occur while stopping drug use lead to prescription of antidepressants when the pathology is recognised.

> Q: *«C'était avec vous le sevrage ou bien il avait été en cure?»*
>
> M: *«Il avait été pour le sevrage de la toxicomanie? Non non il avait arrêté en même temps que l'alcool et il était pas très dépendant, il commençait vraiment, avant que son épouse lui dise bon ben ça suffit arrête-moi tout ça maintenant. Donc, il a tout arrêté, malheureusement elle a ... pour d'autres raisons elle est partie. Donc là, il est plutôt dépressif donc avec prozac et un puis un traitement pour sa bronchite. Et là pour le moment, j'ai pas rajouté d'antidépresseur, non, d'anxiolytiques, plus un suivi aussi, un soutien psychothérapeutique, surtout pour faciliter»* (49)

Beyond this context, invalidity due to a multiple pathology, dependence on family and particularly on a spouse, the breaking off of professional relationships at retirement and, for sailors, confinement with a spouse who is not used to living with her husband, incite the physician to propose medication as help.

> *«Il est obligé de se taper sa femme toute la journée ... comme il est assez fragile ... là maintenant, il est sous antidépresseurs parce qu'elle est insupportable quoi ...»* (50)

Nevertheless, once again, this assistance, which is intended to "manage the anxiety" of a serious disease such as breast cancer, is given as necessary only when the husband is not supportive but defective or hostile.

> *«et puis bon, je crois qu'il ne parle pas trop de la maladie de sa femme, mais il la supporte à mon avis très mal parce qu'il connaît le pronostic ... et puis il sent qu'un jour ou l'autre il va se retrouver tout seul»* (51)

The physicians link the prescription of anti-depressants to elderly patients (between 70 and 90 years old) to the anxiety of solitude or a fear of death that the elderly must confront alone during the long nights in retirement homes. The doctors think that the elderly have to combat this by hypnotics. Of course these patients are often also sick and bereaved, but their main problem is solitude, *«le handicap majeur, se retrouver seule dans la vie sans perspective autre qu'une vieillesse très handicapante»* (52). So when an 88-year old woman seems «much improved» (*«sensiblement améliorée»*) with medication and a stay in a rest home, this improvement can either be ascribed to the treatment (*«est-ce la raison?»*), or to playing dominoes with her companions.

Pressure encountered in the workplace, moral harassment of a union militant, or working conditions requiring mobility, which are the cause of depressions that are sometimes called "reactive", do not necessarily lead to a prescription.

In the region studied, which is not propitious for migrations but welcomes refugees, the suffering of expatriation may be surmounted for a while, and then people spill it all out one day in the doctor's office. This is the case of two young women; one who «drags through life» (*«traîne sa vie»*) with the impossible mourning for a father who was killed, undoubtedly in obscure circumstances, in the Balkan war, and the other who wears herself out trying to protect her children from a loss of social status and supporting her husband through the difficult period of professional reinsertion.

But the clear "reasons" behind these "breakdowns" should not mask the fact, hinted at by the physicians, that the recourse to medication is deemed necessary only as a release, to disembody suffering that is so massive that it is unspoken, or that cannot be spoken about under prevailing conditions.

Conclusion

For the family doctors who were asked to situate the prescription of antidepressant medication in an account of their therapeutic relationships with patients, the meaning of this practice extends far beyond the treatment of depressive entities as defined by various diagnostic handbooks. While these criteria may provide a framework, and justify the practice, they are very rarely the first aspects mentioned in this context. In the "culture" of these general practitioners on the front lines of social and even psychiatric suffering, it is difficult to detach the illness from the patient who experiences it. Like the patient, the doctors look for meaning in the illness and seek to place it in a personal context. Antidepressants emerge as tools in the care relationships, useful for "unblocking", "getting things moving", so as to make patients intelligible and possible to treat. The practitioners neither belong to the domain of psychotherapy, nor to the practice of psychiatry, but they follow fluctuating diagnoses and frequently renews highly complex psychiatric treatments; their analyses, however, apply to the familial and social context of their patients. Faced with psychic suffering, depression and problems in coping with life, the general practitioner does not pose as a clinical worker tracing the pathway from the analysis of pathological signs to clinical diagnosis and then to the drawing up of a therapeutic strategy. The approach is both more detailed and more complex. Clearly the prime concern is the patient's well being and the preoccupation is to "take care" of the patient. The family Doctor has indeed a caring function.

We have seen that the physicians put emphasis not so much on "life events", no matter how tragic, but rather the lack of outlets and a deficit of expression stemming from these events, as underpinning the "biologisation" in the form of illness. This is the case when the symptom is one of the "cardinal symptoms" of depression or any other symptom that they analyse as being a somatisation. Prescription of antidepressants, rather than the explicit diagnosis of depression, thus appears to be central for an analysis of "the interactions of social and biological aspects" in the framework of the system of signification which is the medical system, according to medical anthropology. This analysis would be but one contribution to a broader anthropology of medication (Van der Geest, Whyte and Hardon 1996), which would have to cover other actors, including the consumers themselves. This will be the next stage in our work. It would also be interesting to have physicians explicitly discuss the problems they encounter in handling depression, through focus group discussions. Analysing discussions from this type of consultation, while difficult, and would shed light on the subject of this culture-specific idiom of psychological distress (Massé 1999).

While the prescription of antidepressants can be analysed as a ritual, which the organisers understand in the meaning given to it by an interactionist perspective, we have analysed only the exegetic version, according to V. Turner, of one set of actors. This version suggests, however, that the rupture that this ritual tries to introduce, breaking with the anomie, the lack of purpose, meaning and direction in a situation and a society without communication, would be that which the patient can only embody via illness. The "social fact" named by Mauss harks back to Durkheim, and leaves us with our initial question, which is certainly a French preoccupation, regarding the specificity of anthropology with respect to sociology, two historically distinct disciplines in our country.

Notes

(1) Anthropologist and pharmacist, Faculté de Médecine de Brest / CESAMES.

(2) Psychiatrist, Service Alcool Toxiques CHU Brest.

(3) General practitioner, associate professor at the Faculté de Médecine de Brest.

(4) A prevalence of 9.1% in France according to the European survey "Depression Research in European Society (DEPRES) which used precisely this questionnaire.

(5) Respectively 126.2 (Finistère) and 108.3 (Côtes d'Armor) cases of mortality due to liver cirrhosis, alcoholic psychosis, VAD cancers, per 100,000 men between the ages of 25 and 64 for the period 1995-1997 (sources INSERM SC8 INSEE reference population France RGP 1999).

(6) 21.5 men and 8.4 women per 100,000 between the ages of 15 and 24 (sources *ibid.)*

(7) 903 visits, of which 401 elicited comments, 92 of which mentioned depression, MDP or prescription of antidepressants in one way or another.

(8) Regarding the comments on the rest of the week: 2 problems of dependency/10 for GP1, 3/3 for GP2, 5/14 for GP3, 4/8 for GP4, 8/20 for GP5, 10/18 for GP6, 4/8 for GP7, 23/36 for GP8, and 5/8 for GP9 (GP10 did not comment upon the patients seen during the week).

(9) 92 occurrences.

(10) It goes without saying that these figures are purely indicative, and serve only to put these physicians in context.

(11) [«Question: But when she came in for her depression, she was the one who said that she was depressed or were you the one that diagnosed it? How did it go?»

Practitioner: «Well, she came in crying»

Q: «Ah, she came in crying»

P: «She came in crying and saying that she wasn't at all well. She didn't ask me what was happening to her, but she came in saying what she had and that she was doing very poorly and so the diagnostis of depression, of a reactional depressive state was established for the sleep problems and there weren't any physical problems but there was a lack of enthusiasm in everything she did and so on, heh and that's how the diagnosis was established. But there was a demand, there was a demand, heh». (733)]

(12) [«... and he was depressive, for me he was depressive».

Q: «He had insomnia, he had...?»

P: «He wakes up tired, he's tired all day long, he has pains everywhere and he doesn't feel like doing anything, he doesn't want to read. He has the cardinal signs of depression.»]

(13) (735) concerning *«une maladie de parkinson, très peu évolutive bien contrôlée par le traitement mais qu'il vit très mal psychologiquement...»* «a Parkinson's disease, very little progression well controlled by treatment but psychologically he's very badly off».

(14) [«maybe, maybe the morning insomnia is missing, um, and even so I think he wakes up fairly early, but what is dominant are the somatic disorders, anhedonia and fatigue, um, those are the three tableaux»].

(15) [«She's a little lady who never feels good with herself... I sometimes manage it so that she leaves here smiling whereas she always comes in feeling very sad.»]

(16) [«Well, he's a very old man of 83 who has always been a bit depressive, I put him on antidepressants 16 or 17 years ago when I first came here, because he and his wife were very sad. They had just retired and they were right sad both of them.»]

(17) [«He was a man who was closed up because he was depressive, depressive because at work they wanted to get rid of him.»]

(18) [«She has been taking since the death of her son who was ill for a long time before dying so for a year she was he was rather sick and then he was in care, later if you will he was in a coma for nearly three months so it was very very hard for her and since then she takes an antidepressant.»]

(19) [«She's a lady that I know quite well, who, whom I have had since I met her twenty years ago when she was, I'd say, a social alcoholic, wife of a prominent citizen, somewhat bored all by herself alcohol consumption way over what one can accept. Her son was killed in an automobile accident, which didn't help any... I think now she doesn't drink any more, she doesn't smoke anymore, right that goes back ten, twelve years, um, but in contrast she has this depressive nature with which I associate consumption of alcohol. This depressive nature comes out cyclically, so there I had her, at the beginning of the year I put her on Deroxat* and it went well, she was rather positive.»]

(20) [«When her husband passed away she was very sad apparently but in fact she began to spend compulsively all they had saved up and so I had the occasion to see her at her home and I asked her about it several times and I told her that if, she was very sad of course about the events but that no doubt she had a tendency to abuse a little the drinks in the evening notably, well it's because of the loneliness, the next morning she must be even sadder what, and there, every time she minimised whereas the neighbours were telling me that she got home at 10 or 11 in the evening in a state that left no room for doubt.»]

(21) [«She has a son who has, who is very depressive a little bit, a little bit manic-depressive, a bachelor who is over 60 also.»]

(22) [«Now there pff I have no idea, she was a lady, a very serious psycho. Well she takes medication to sleep as well. But she's psycho, um, me I wrote down sensitive paranoia, that's me who makes that kind of diagnosis but, in the sense that she's always crying, she has, always complaining, she cries as she talks, without tears you see? so she really has a problem and according to her children she's nonetheless better off since she's been on Tercian* that (?) her a little bit, and well she wasn't lucky either she had she had one or two children who died young.»]

(23) [«who had lost her husband and who is coping all by herself... that's fairly rare in general, most old people are often on anxiolytics, antidepressants as far as they were concerned... she had largely the ability to cope on her own.»]

(24) [«It's all good and well to say that it's a colopathy. Fine. It's psychosomatic but at the same time is it really psychosomatic, eh? It's, we are we are in. On the other hand, the tests. God knows she had had tests, so is it necessary to go even further? I don't know... Now I'm a bit bothered because I don't really understand much anymore, I don't understand why now. But at the same time, at the same time maybe it's because there is suffering which which which isn't understood and nobody touches it and, well OK we'll go see. And so she, with medication, this

woman had never had psychotropic treatment, as far as I recall… That's a thing, problematic, that is going to pose problems, that isn't resolved, I'm not even sure that it will be resolved someday.»]

(25) [«It was therefore really an anxio-depressive syndrome»].

(26) [«It was truly totally psychosomatic»].

(27) [«So I gave her an antidepressant that worked well»].

(28) [«Every month or two I see her with the same complaints, so I listen to her and renew her treatment so it changes»]

(29) [«Well, she comes to complain, get it off her chest a little is my impression»].

(30) [«If I try to suggest that she has worries that could… pof, locked up right away, I can't do anything with her… So I think there is something behind that she doesn't want to talk about, consciously or unconsciously»]

(31) [«… that it's a serious one, a serious one as well, a diabetic who has very very compulsive behaviour with incredible drunken sprees, who sometimes closes the door on the nurses, I I practically suicidal, practically suicidal…, he is very aggressive… So he also had a heart attack, he is on Effexor… so there you have it.»]

(32) [«He is on an antidepressant and that suits him, so there»].

(33) [«She's OK, so there»].

(34) [«That's really the medication that she needed, and indeed she's much better»].

(35) [«Finally she found that it wasn't bad»]

(36) [«It seemed to be a bit better»].

(37) [«He seems to have gotten his good spirits back»].

(38) [«I'd like to help her but in my opinion for the time being 'I don't have a hold on her', what, I don't have a hold on her»].

(39) [«Very interesting 'contact', we have good chats together»].

(40) [«I try to have a very close relationship with the patient, if I know the patient too well I send him to a psychiatrist»]

(41) [«And so, well so in addition, but I haven't really dug down because unfortunately usually, it's true when I see them for the first time, I take more time and so here it was a bit acrobatic so I couldn't, but we will get together again, we'll talk about it… and then clearly the (gentle medicine practitioner) who has been following her put her on Séropram* and Lexomil* not long ago and that, but I haven't really gotten into this, to know what was the reason for her depressive state since she is in love, but so there. There you have it.»]

(42) [«No real worries on the surface, except that when you scratched down a bit… came for insignificant reasons, we start to talk… broke down suddenly. Really I was flabbergasted, and in fact she tells me about a family affair, big conflict between the brother and the sister and the mother… sobbing all the time»].

(43) [«Now this was a very very introverted fellow, there are very big conjugal problems that he is absolutely unable to talk about. It was the wife who told me that eh? (laughter) and he had episodes, he still does, I think he's a fellow who is profoundly depressive. But who can't express anything whatsoever. His wife told me, that he he had had suicidal impulses. I talked with him about it but he never recognised it. He had sleep problems, poor sleep patterns that were very very major, he didn't sleep at all, he, but well he never accepted, I never managed to get him… I mean he never succeeded in expressing anything whatsoever, he always refused to be helped, whether by me or by a, a a therapist, the only thing that he accepted at one time, because well he wanted to sleep and me I said to him listen, the sleep problems are in all likelihood related to a depression, I'd like to give you an antidepressant to see and then afterwards if that unblocks the situation we can maybe talk about it again, because obviously he is better, but he didn't go any further, and and he stopped after two months, two three months, and then. So I saw him regularly every two weeks, but that, it was a wall, what. He said yes, he was better, I sleep better. So now what, well nothing. So

there you have it. Life goes on, he doesn't take medication but he isn't well, neither is his wife for that matter.»]

(44) [«She is depressive, this lady. She is depressive but she is depressive so she is surely addicted to her temesta for sleeping, but then she has reasons, eh, she has she has her daughter who is hemiplegic who has just shown up, I mean who is there, who is that they have cared for at their home for two years and so, it's very difficult to live together and her son died suddenly this year, so she has some reasons to gobble temesta, eh. And prozac.»]

(45) [«She said to me 'I can't cope'... her husband died no one ever knew what of, even after the autopsy. It's hard to explain to her»]

(46) [«The mother had a depression, she managed for a while and then there it is»].

(47) [«Antidepressant treatment because she really wasn't well... now she's better because she has also found a social connection, she is working... the problem of the son isn't settled... it's true that we talk a little about all that during the visits.»]

(48) *«/ et puis bon, on est un peu dans une impasse parce que je lui ai dit, bon du coup on a mis les choses à plat, je lui ai dit écoutez pour moi c'est, je lui ai déjà dit mais je pense que vraiment c'est dépressif, et que/ bon il faut, il faut essayer de comprendre ce qui va pas, pourquoi ça va pas, ça fait six sept ans huit ans que ça dure , vous allez pas vous en sortir comme ça, quoi. Je m'en fous, je veux pas. Bon. (RIRES) c'est pas facile hein, parce que on est un petit peu coincé, enfin coincé ou pas coincé, on peut continuer comme ça hein, y'en a des tas qui font.. Mais si on veut faire bouger les choses, là on est, on, on a créé en fait, on, on les a amenés là où ils sont, quoi, enfin en tout cas on les a accompagnés, solidement accompagnés (SOURIRE) et puis /, on fait machine arrière, c'est pas facile. Alors, bon, / là encore je lui dit écoutez on fait l'essai, prenez un traitement anti-dépresseur, au moins bon. Elle a accepté, elle dort mieux. (SOURIRES) ben c'est déjà bien. c'est déjà bien parce que / au moins ça l'a amenée à se poser la question, au moins ça, quoi hein. Je dors mieux, / indéniablement je dors mieux qu'avec tout ce que j'ai eu jusqu'à maintenant avec mon deroxat. Ça c'est clair. Alors qu'est-ce que ça veut dire hein ? puisque ça, c'est facile d'expliquer un cas où ça, c'est pas un hypnotique un truc-là, hein ? si ça marche, c'est que quelque part il y a un fond dépressif, y'a quelque chose quoi. Bon alors on va essayé de travailler là-dessus quoi. / peut-être que/ elle finira par accepter»*

«And so then, we are sort of at a dead-end because I said to her, so then we put everything on the table, I said to her listen for me it's, I had already told her but I think it is really depressive, and that well we have, we have to try to understand what is wrong, why it is wrong, this has been going on for six seven eight years you aren't going to make it this way, what. I don't care, I don't want to. OK. (LAUGHTER) it isn't easy, heh, because we are sort of stuck, at any rate stuck or not stuck, we can keep on this way, heaps of people do... But if you want to get things moving, there you are, one, one has created in fact, one has led them to the point where they are, what, at least in any event one has accompanied them, solidly accompanied (SMILE) and then, we backslide, it isn't easy. So well, once again I said listen let's give it a try, take an antidepressant medication, anyway. She accepted, she sleeps better (SMILES) so that's already something. that's already something because at least it made her ask herself the question, at least that, what. I sleep better, undeniably I sleep better than with everything I had up to now with my deroxat. That is clear. So what does that mean heh? because that, it's easy to explain a case where that, it isn't a hypnotic that thing, heh? if it works, it's that somewhere there is a depressive nature, there's something there. Good so we are going to try to work on that, what. Maybe she will accept in the end.»

(49) [Q: «Was the cut-off with you or had he been in treatment?»

"P: «Had he been in treatment to get off drugs? No no he stopped at the same time he stopped alcohol and he wasn't very dependent, he was starting really, before his wife told him OK that's enough, stop it all right now. So, he stopped it all, unfortunately she... for other reasons she left. So there, he was more or less depressive so with Prozac and then treatment for his bronchitis. And for the moment I haven't added on an antidepressant, no, anxiolytics, plus follow-up also, a psychotherapeutic support, above all to make it easier.»]

(50) [«He has to put up with his wife all day long ... since he is rather fragile ... so now, he is on antidepressants because she is impossible to live with, what.»]

(51) [«And then, I think he doesn't talk about his wife's illness too much, but he can't accept it in my opinion at all because he knows the prognosis... and then he realises that one day he will find himself all alone.»]

(52) [«The main handicap, to find oneself all alone in life with no perspective other than a very debilitating old age.»]

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EPILOGUE

AM
Rivista della Società italiana di antropologia medica / 13-14, ottobre 2002, pp. 395-399

Reflections and future paths

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> «Anthropology would make a difference because relationships make a difference» (Carrithers 1992)
>
> «Some believe that ethnologists, homeward bound now, might as well surrender themselves to the sirens of disenchantment. But the ethnologist never comes home» (Augé 1999)

This volume offers a bouquet of anthropological studies about suffering and illness. These contributions show that medical anthropology is at home domestically, and that anthropologists have been able to maintain their wonder about the cultural richness ‘right under their noses’. We must realise that it is only several decades ago that medical anthropologists began to take an interest in their own societies and cultures (though there are of course exceptions, like the Italian anthropologist De Martino, who have always worked ‘at home’). Given the short time that medical anthropology has studied what is under our noses, the work that the papers in this volume do to show that anthropology is a discipline which transforms the taken-for-granted realities at home into questionable cultural processes is all the more impressive. Again and again we see that anthropology’s methodology and theory can be applied everywhere. The themes of the volume have ‘produced enduring answers’, which – in my opinion – can be seen «as ways of formulating questions» (Frankenberg 1995). New themes and issues have emerged from this volume. Each part, in turn, invites us to rethink our methodologies and approaches and challenges us to question what we have found.

The papers have made clear that narratives and narration are central focuses in anthropology. With stories, people try to shape their pasts and futures. «To tell a story is to take arms against the threat of time… the telling of a story preserves the teller from oblivion», Portelli wrote in 1981. Anthropologists agree that a story, a narrative, is more than a recital of events. A narrative organises experience, gives coherence to someone’s life, reveals some of the elements of one’s identity, and makes sense of one's life and many other things. Through stories, culture "speaks"; culture is reproduced and (re)created by the teller and the listener. Narratives and stories have charm. They move, evoke worlds of the past, they reveal dreams and fantasies, and they are sometimes about the 'poetics of suffering'. Of course, words are indispensable in anthropological work but, sometimes, I wonder if anthropologists have focused too much on words. Talk is just one practice among many others. It is interesting that anthropology's recent interest in the 'body' and embodiment (Van Dongen and Comelles [i.p.]) has hardly tackled the critical methodological problem of representation (through words) and 'being-in-the-world' (through sensing). The exploration of «experience in all its sensual modalities» (Good 1994: 123) still largely relies on narrativisation of the worlds of our informants, through which they represent their bodies and the world of 'the flesh'. Many would argue that one couldn't really study experience because experience is always mediated by language. Yet I would like to argue that a methodological standpoint capturing the immediacy of bodily experience – 'radical empiricism' as Stoller in 1989 termed it – enables the development of a 'sense-itive' anthropology. The focus on narrativisation leads me to the question: What exactly has happened to 'participant observation' and ethnographic writing in Medical Anthropology at Home? It seems that, because it is sometimes impossible to do long-term research in one's own society (1) and because it is hard to find time to 'hang around', we might have lost our 'taste of things'. I am not saying that medical anthropology at home has become 'scientistic' or has narrowed itself to the 'intelligible', the 'intellectual' or the 'cognitive'. Some of the papers in this volume are 'leaning against the wind' and show how impressive the knowledge obtained by this 'sensing' (and moving) can be. However, in future research, these other dimensions of ethnography and anthropological fieldwork may be more extensively discussed in the network of medical anthropologists who work at home, so that the 'charms' of anthropology at home can be fully revealed.

In medical anthropology, there is also a tendency to focus on biomedicine. Of course, biomedical thinking and practices merge deeply into people's lives and into their illness explanations. The many existing and excellent studies within medical anthropological research at home may have suggested that biomedicine is 'all that matters' for people. In this volume, it becomes clear that biomedicine is but one of the paths people follows when they suffer. The papers show for example, how religion and suffering are closely linked. Religion is important to curing, but also has a broader scope; saints are "used" as social instruments of healing. Collective mental and social structures of long duration (Braudel) play a role in issues of health and suffering; everyday life theories and history are brought to life by ethnographic research. There seems to be a link between these studies and the geographical area of "home". Why is it that folk-life studies or studies of 'collective and mental structures of long duration' are an important part of medical anthropology at home in Scandinavian and Mediterranean countries and do not have (or rarely have) such a position in other parts of Europe? (2) Jackson (1987) has already taken up this issue for anthropology at home in general. He argues that the reason is that these studies express a strong concern with separate identities. In the same volume, Ardener (1987) discusses 'remoteness' in relation to the interest in 'folk-life'. Remote areas, Ardener argues, are event-rich or event-dense, which is the result of «the weakening of [...] the maintenance of a self-generated set of overriding social definitions [...] thus rendering possible the 'disenchantment' of individuals ...» (p. 59-50). Then, how might anthropology study 'folk-life' in relation to illness? Historically, folk-life studies were also part of ethnology, because they could help ethnologists to understand the use of objects and to trace the diffusion of tales and myths (Jackson 1987: 4). Also the use of concepts like magic and miracles, liturgies and rituals provide us with a lively understanding of how the different 'compartments' of social life are interwoven and how people act upon suffering. The distinction between 'enchanted' and 'disenchanted' worlds can be misleading, as Reynolds Whyte (1997) correctly points out. Illnesses are also associated with uncertainties of human relationships. Biomedicine has so far failed to live up its promise of miraculous cures and magic bullets. People turn towards other possibilities. In this sense, medical anthropology could study 'folk-life'. It would help medical anthropology to trace 'deep' health beliefs and behaviours that are grounded in history and still echo in people's health behaviour. On the other hand, to find new ones that come with the many who have entered the different regions of 'home'. For example, within Europe complementary medicine is the subject of policies and regulations in many countries. It is often overviewed that 'complementary medicine' contains many elements of historical sorts of health practices from home and elsewhere, and that it is firmly rooted in the history of cultures. Historical-cultural health practices and beliefs are also still alive in biomedical practices. The consequence is that biomedicine has a non-universal status. Different 'biomedicine's' exist. They are grounded in beliefs about social relationships, the body, religion and worldviews. Medical anthropology would allow the 'differences within' the homes to be viewed (Moore 1994), but the papers in this volume also offer possibilities for explicit comparison between the different homes. This issue may be taken up in the future in medical anthropology at home, so that the anthropological science can bring about «the essential sameness of the human being as a social being» (Fainzang 2000) and the essential processes and elements that underlie illness behaviour at home and elsewhere.

The relationship between medicine (and other disciplines) and medical anthropology is still opaque. Anthropologists often have to say how the understanding and knowledge could be applied or is "of use". There are many answers to give and even more questions to ask, but the papers in this volume show that biomedical therapies reach far beyond the illness. They are also 'tools' to shape human relationships. Medical anthropology shows that biomedicine is not a 'cool-hearted' way of healing. It is soaked with culture and therefore human. Besides, anthropological knowledge may empower people and even offers the natives ethnographic understanding to revitalise practices and discourses of old structures and healing activities in the local politics of culture.

Ethnographic writing is much criticised – by anthropology itself and by others – but it will be precisely ethnographic writing that will raise new questions for further investigation.

Notes

(1) I will not discuss the reasons and causes of this process. See Clifford and Marcus 1986; Jackson 1987; Stoller 1989.

(2) Except Germany and those regions that have great interest in folk-life studies (Celts, Bretons, Irish, Welsh, etc.).

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