CONTRIBUTIONS AND CHALLENGES OF MEDICAL ANTHROPOLOGY TO ANTHROPOLOGY: INTEGRATION OF MULTIPLE DIMENSIONS OF SOCIAL SUFFERING AND THE MEDICALIZATION OF MEDICAL ANTHROPOLOGY

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Introduction: the importance of medical anthropology as a sub-discipline

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

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

It seems obvious that one of the first contributions of medical anthropology to anthropology has been the popularization of the anthropological discipline among the administrators of public institutions, other social science disciplines and the general public. More than any other sub-discipline, medical anthropology has helped to position anthropology as a major discipline among the social sciences. Anthropology is no longer seen as a fundamental field of research on exotic cultures or minority cultures in pluri-ethnic societies. It is now known to the general public as an applied social science, and one that is applicable to the solution of concrete problems. Often associated with “soft” methodologies, henceforth it will be known as an innovative discipline in qualitative methodologies and as a discipline known for its flexibility (e.g., Rapid Ethnographic Assessment Methodology). The image of the isolated, individualistic fieldworker anthropologist will be replaced by the image of a helpful and credible partner in multidisciplinary teams.

In brief, medical anthropology, more than any other sub-discipline, has contributed to building the scientific credibility and positive social image of anthropology. This new credibility is opening doors for anthropologists to national institutions of public health (e.g., Centres for Disease Control, public health administration, community health programs) and numerous international public and private organizations. This relative
abundance of employment offers for medical anthropologists, coupled with the appeal intrinsic to a sub-discipline which harmonizes practice and theory, will ensure Anglo-Saxon university departments of anthropology of a stabilization, if not an increase, in student clientele. It could be hypothesized that our European counterparts will soon experience the same trend.

**Contributions to classic fields of research in anthropology**

Of course, the contribution of medical anthropology is not restricted to this marketing function, which has established the credibility and popularity of anthropology. It has also allowed a fundamental deepening of analysis in several fields of classic research in anthropology. Here are a few examples.

1) Medical anthropology has led to a confirmation of the importance of the holistic and systemic approach in anthropology. Since the classic works of Clements (1932) and Rivers (1924), ethnomedicine has become one of the essential dimensions of culture to be investigated. As suggested by Rubel and Hass in a functionalist perspective, "One of the most prominent ways in which ethnomedicine contributed to the development of theory and method in sociocultural anthropology was to show the functional integration of the components of health care institutions within society's cultural matrix, its social organization, or political system" (Rubel and Hass, 1990; 116).
2) Through its analyses of the introduction of biomedicine in traditional societies, medical anthropology has become one of the most prominent fields in the study of acculturation mechanisms and local processes of reinterpretation of foreign practices and knowledge. The anthropology of biomedicine is becoming a leading research field with respect to sub-development and the globalization phenomenon through the study of the internationalization process of knowledge and biomedical care practices.

3) Ethnomedicine has also become one of the leading fields for the analysis of alternatives to biomedicine and strategies of local resistance to new forms of power, namely, the forms associated with biopower in a critical anthropological perspective (Baer, Singer and Susser, 1997, Berche, 1999).

In fact, this list could be extended to include the range of problems covered by modern anthropology (feminist studies, immigration, identity, cultural and ethical relativism, public policies and so on): all issues that have been discussed with a renewed emphasis as they were embedded in the fields of illness and health services.

Production of new concepts and theories

Once again, the contributions of medical anthropology are not limited to the dynamization and renewal of the research traditionally associated with anthropology. Its questioning of the role of cultural and social factors in the analysis of the causes of disease and its unequal distribution through time and space has contributed to a renewal of the ecological and theoretical models of the role of the environment and to a
reorientation of traditional physical anthropology. Analysis of the sociocultural construction of illness has stimulated refinement of the cognitive and interpretative theoretical models. In reaction to criticism in the early 1970s concerning its lack of theorization and a propensity to in-depth description, the sub-discipline has, in fact, shifted ground since the late 1970s. “The 1980s was a time of ferment in academia, marked by debates between advocates of critical theory, feminism, and postmodernism; [...] studies of cultural knowledge structures and embodied knowledge; [and] a time of theory postering” recalls Nichert (1991:1). Many important concepts, models and theories have been suggested which focus on either the semiotic and interpretative (i.e., concepts of idiom of distress; semantic network, illness explanatory model), economo-political (i.e., theories of resistance or biopower in critical medical anthropology), or phenomenological (i.e., concepts of the existential field of illness, embodiment) dimensions of illness experience. The production and refinement of these concepts and theories can be seen as one of the most important contributions of medical anthropology to the discipline. I believe that some of us should, in the near future, take up the challenge of such a history of the interactions between concepts and theories in medical anthropology and the mother discipline.

The contributions underlined up until now may appear somewhat factual and obvious. However, in the following pages, I will emphasize what I consider to be two major challenges which medical anthropology will have to face in the years ahead. These challenges represent, from my point of view, two major tests for the whole anthropological discipline. If medical anthropology succeeds in accepting these
challenges, it will contribute significantly to the evolution of anthropology as a social science, as much on the theoretical level as at the level of applied anthropology. The first challenge is the articulation between multiple dimensions of illness experience. More specifically (and this difficulty is a challenge for any sub-discipline in anthropology), the theoretical endeavour will have to focus on an analysis of the interrelationship between three dimensions of illness: 1) the individual dimension (related to an analysis of the daily personal experience of illness and the physical and social environment in which the disease is experienced), 2) the socio-cultural dimension (sociological and cultural characteristics of the society and the ethnic group concerned), and 3) the politico-economic dimension (i.e., the organization of the care system, political causes concerning inequality facing care and health, asymmetric power relations between caregivers, administrators and patients as well as between rich and poor countries). The theoretical challenge is one of complementarity between the phenomenological, interpretative and critical perspectives, and of the articulation between micro- and macro-analysis. The second challenge involves the denaturalization of the anthropological in medical anthropology, through the influence of the medicalization of anthropology. Medical anthropology has contributed to the renewal and dynamization of research in several classic problems in anthropology, and promoted the development of concepts and theoretical models which enriched the parent discipline, but the excessive medicalization of medical anthropology could also have negative impacts on anthropology. If it permits anthropology to consolidate its scientific credibility and rise in the competitive field of social sciences, a possible denaturalization of medical anthropology could denaturalize anthropology itself. Insofar as it will be able to accept these two challenges, medical
anthropology will continue to contribute to discussions about the nature and place of anthropology in the social sciences field.

THE CHALLENGE OF THE COMMENSURABILITY OF PHENOMENAL, INTERPRETATIVIST AND CRITICAL ANALYSES OF ILLNESS

Few concepts and theories have been dedicated to explaining the interrelationship of illness experience to the multiple dimensions of reality and to the interface between these multiple layers of the illness experience. Yet, I believe that it is at this level that the major challenge exists for contemporary medical anthropology. I will briefly summarize three approaches which now coexist within the discipline.

1) Ethnographic works have described the folk beliefs associated with nature and the causes of illness, and these beliefs are conceived as being organized into coherent systems. Such an approach, described by Good (1994) as empiricist, has the flaw of considering beliefs as well-defined statements, as easily identifiable concrete entities, and therefore modifiable by health education programs. Such a reification of both beliefs and culture considered as a cultural system has been attractive to health professionals looking for concrete cultural targets for public health programs and to those relying on psychosocial predictive models such as the Health Belief Model (see Massé, 1995:130-141). This empiricist paradigm is also based on “rationalist theories of medical beliefs,
the ecological theories of ethnomedical systems as essentially adaptative, and analytic primacy of choice in studies of illness behaviour" (Good, 1994.44).

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

3) Anglo-Saxon critical medical anthropology is characterized by an emphasis on a) the structural, political and economic causes of illness, b) the asymmetric power relationships (gender, ethnic, class) which influence practitioner-patient relations, and c) the strategies used to confirm the hegemonic position of biomedicine in comparison with ethnomedicines. With a particular emphasis on the influence of the world economic and political system on the distribution of illness and care (Frankenberg, 1980, Baer, Singer and Susser, 1997), this approach postulates that the main, but latent function of ill-being medicalization, would be the resolution of social conflicts (Swann, 1989), giving the advantage to dominant economic and political classes.

In response to these biomedical and cultural deviations, critical medical anthropology has divided itself into two camps. In the first, a political economy focuses its attention on a macro-analysis of the effects of international policies for health causes and treatments
This approach, considered the missing link in medical anthropology (Morsy, 1979), emphasizes the links between local sociocultural dynamics and historically determined national, international, political and economic processes (Morsy, 1996) as well as on dependency relationships between rich and poor countries (Morgan, 1987). In the second approach, critical interpretative anthropology (Lock and Schepet-Hughes, 1996) takes on a radical phenomenological approach. For Lock and Sheper-Hughes (1996), the meaning of suffering evolves continuously to the confluence of three bodies, i.e., under the influence of individuals’ lived experience (embodiment in individual body), of symbolic representations held by the society (social body), and of the politics used to control and discipline individuals (body politic).

The issue which constitutes, in my opinion, one of the major challenges to medical anthropology at the beginning of the 21st century is the articulation between these interpretative and critical perspectives. If the approach of radical phenomenology advocated by Nancy Sheper-Hughes, among others, partially succeeds to conciliate an explanation and interpretation of illness, the political economy approach to health distances us from such an arrangement. Such an approach has been criticized (Morgan, 1987), among other things, for an excessive transcultural application of Western concepts about gender and class relations, for the avoidance of the analysis of ethnomedicine as a form of local resistance to biomedical hegemony or as an expression of the creativity of dominated cultures, and for its lack of concern for the issue of positive impacts on population health of externally induced economic development. However, it is not easy to achieve this complementarity of approaches without falling into the trap of the
overdetermination of the meaning of suffering and the delegitimization of discourse and local methods of health-seeking process (Kleinman, 1992).

This challenge of conciliation (a priori reconcilable with difficulty) of, on the one hand, the analysis of international political and economic macrostructures and agendas and, on the other hand, the analysis of local interpretations of disease and local health care practices, goes through the modelling of articulation among the varied dimensions of illness. For example, Singer and Baer (1995) have proposed a model of analysis of health-related behaviours integrating four levels: 1) a macro-social level referring to a world capitalist system and to international economic corporations and institutions, 2) a social intermediary level which emphasizes the role of biomedical and ethnomedicine care institutions, 3) a micro social level which refers to interactions between patients and medicine men, and finally 4) an individual level linked to relations that individuals maintain with their social network, their lived experiences with illness, and their personal psychological and physical systems. Bibeau (1996), for his part, proposes a three-dimensional analysis model. It emphasizes 1) the interfaces between macrosociological forces determining the semiologic patterning of reality, 2) the historical context and power relations in which cultural values have been developed, but which, at the same time, take mediating categories into consideration and for which cultural codes are articulated in the macrosocial context, and 3) the use people make of that during their daily experience. The new medical anthropology will be constructed, according to Bibeau, on the clarification of intermediary levels between outside forces and local sociocultural organizations. It will also rely on an analysis of the interfaces between the
multiple dimensions of reality, if it wants to build a comprehensive conceptual framework to bridge the gaps created by the tendency to fragment and decompose reality (Bibeau, 1996:410). Such an endeavour, I believe, could help counterbalance the postmodern-literary, as well as the politico-economic, drifts in anthropology. It should be remembered that anthropology's utmost goal and mission is to produce a comprehensive, multidimensional, encompassing interpretation of the human experience in a world in constant evolution.

However, even though several people recognize the theoretical importance of combining these various interpretative and critical analysis levels, this objective is rarely attained, or even identified, in ethnographic works published in medical anthropology. Some examples of specialists could be mentioned here, such as Kleinman (1986) on the social origin of distress in China, or Farmer (1996) who, in his study of AIDS in Haiti, calls for an anthropology that goes beyond the search for cultural meaning (the eternal object of research on ideas and symbols), for an anthropology that shows AIDS in Haiti is clearly in keeping with a political and economic crisis rooted in the social and economic structures inherited from colonial times. The challenge is therefore to accept an interpretative anthropology of suffering, sensitive to local historical and individual consequences and concerned with the economic and symbolic power relations of suffering (Farmer, 1988:80). In particular, I believe the concept of social suffering makes such a contribution, as it deepens the analysis of the interconnectedness among politico-economic, socio-cultural and phenomenological dimensions of suffering. This concept was explained in a recent paper (Massé, 2001), which described the outlines of a critical
ethnoepidemiology of social suffering in the French Caribbean based on the explicit goal of complementarity between phenomenological, interpretative and economic and political perspectives.

Such a challenge is at the very heart of the whole discipline of anthropology (and perhaps all social sciences), and concerns the issues of economic globalization, post-colonialism and sub-development. However, I also believe that this challenge concentrates on the health and illness field. In fact, while it is obvious that social and economic inequalities at national and international levels explain the over-exposure of some populations to risk factors and unhealthy living conditions, it is also true that the illness experience represents a prominent field of study in the role of cognitive and symbolic structures in the sociocultural construction of meaning and in the domain of deeply intimate human experience. Must we give up in the face of this challenge and concede to the incommensurability of these levels of analysis? Or must we make it one of the conditions for the evolution of medical anthropology and for the discipline as a whole? I believe, for my part, that medical anthropology has no other choice than to accept this challenge. To confine oneself to the analysis of cultural representations of health is to condemn oneself to the marginal status of a cultural fact specialist and to the label of exotic specialist. By changing to a political economy of health, one is condemned to manage without the expertise of fieldwork and the emic analysis of illness interpretations and experiences. Anthropology must come back to its preoccupation with a comprehensive understanding of disease. However, two related challenges will have to be accepted if we wish to
conclude these multiple analysis levels: 1) a redefinition of the notion of context and 2) abuse in the anthropological interpretation of illness experience.

The concept of context

The definition of context which serves to delimit the perimeters of anthropological fields is becoming more and more complicated. The exotic ground is not the only pertinent study framework in the context of globalization; rather, the whole planet now gives a new meaning to "local" ground. However, an anthropology of globalization must not move anthropologists away from their concern for local culture. Nor must they focus exclusively on an anthropology "at home". As Copans underlines, returning home must be a step towards expansion, and a release from the inside, a project which must be guided by the observation of world history which is now taking place worldwide (Copans, 2000:31). Do the internationalization of fieldwork via an anthropology of globalization and, at the opposite pole, the fallback position on an anthropology at home, constitute two dimensions of the same phenomenon of relocating anthropology far away from the traditional exotic field? Under what conditions can an anthropology "at home" still nourish reflexivity in anthropological analysis? These are some of the related questions that arise in the definition of context. I strongly believe that inasmuch as it is recognized that culture has an influence, as well as being influenced by social, economical and political determinants, sometimes through very original figures in Western countries, a medical anthropology at home is a fundamental component of medical anthropology.
In the framework of a vigorous defence for a return to what is unique in the ethnographic method, i.e., its reflexivity which gives subjects authority in determining the contexts of their beliefs and practices, Englund and Leach (2000:225) are afraid that the cult of metanarratives of modernity in contemporary anthropology give to anthropologists ready-made speeches on the largest context or the local context. As Gupta underlines, “The central point here is that one cannot assume, as anthropologists have been wont to do, that the local is its own universe, a geographically circumscribed space where meanings are made, where the most important social interactions occur, where economic and affective life is lived, and where social structures are reproduced” (Gupta, 2000: 240). As stated by Appadurai (1996), the fundamental question here, in the analysis of ethnomedicine and of local reinterpretations of biomedical knowledge and practices, is: does the larger-scale perspective yield more knowledge about the narrower context than a focus on the local context itself? I believe, along with Abeles (1996), that anthropology must be careful when faced with the fetishist trap of micro-analysis, and with the illusion that proximity generates, quasi mechanically, a better knowledge of the object (Abeles, 1996:99). Deconstruction of macro-analytic categories could condemn ourselves to an epistemological powerlessness. On the other hand, macro-analytic generalization approaches, and resorting to reified models and concepts, are responsible for oversimplifications which have heavy ideological, and even political, consequences (Lévi, 1996:188). For myself, I believe that in medical anthropology as well as in the anthropology of other modernity problems, we should look for a middle term between macro-analysis of the “world-system” and the classic analysis of exotic local ethnomedicine. The “ethnography of middle-range” suggested by Comaroff (1993) seems
to be a reassuring alternative here. But it entails a deconstruction of the concept of context itself. I am not saying that the wider context does not exist, but I am suggesting that anthropology find a middle way between the inductive, emic approach based on micro-analysis of meaning construction and lived experience, and macro-analysis using the deductive approach through concepts and theories that reflect preconceived views. The risk is to become disengaged from reflexive knowledge production.

**The abuse of interpretation**

Beyond the definition of an intermediary level of analysis between the micro- and macro-social, the question asked by these meta-narratives of modernity is that of the overdetermination of the meaning of illness, or more precisely, the imposition of analysis charts (concepts, theories) which are outside local realities interpreted by the anthropologist. Examples here include the efforts of Horton to demonstrate the rationality, and even scientificalness of magical practices, and the comments of Comaroff (1993) on the fundamentally “magical” bases of beliefs and practices in Western modernity.

The concept of “resistance” is one of these theoretical categories, and a candidate for the status of total deconstruction of illness. It refers, for Kleimman, to “resisting the imposition of dominating definitions (diagnoses), norms defining how we should behave (prescriptions), and official accounts (records) of what has happened. We resist, in the micro-political structure, such oppressive relationships. Such resistance may take the
form of active struggle against dominant forces or a more passive form of "noncompliance" (Kleinman, 1995:126). As applied to human suffering and to ethnomedicine defined as local forms of resistance to the globalization of biomedical care, techniques and values, this concept gives primacy to the search for political meaning over intersubjective and situational meaning with the experience of suffering. "The interpretive requirements of suffering for theodicy – namely, the struggle of rebuilding a coherent account of why misery should exist in the world –, are viewed by many anthropologists as the core reality of suffering. [But] the intersubjective experience of suffering is so various, so multileveled, so open to original inventions, that interpreting it solely as an existential quest for meaning, or as disguised popular critique of dominant ideology, notwithstanding the moral resonance of those foci, is inadequate. It may distort this most deeply human condition" (Klemman, 2000:145).

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

THE CHALLENGE OF THE NON-MEDICALIZATION OF THE ANTHROPOLOGY OF HEALTH

The second challenge medical anthropology has to face is, in my view, that of the risk of disciplinary dissolution and denaturalization in the context of abusive and clumsy borrowing from other social science approaches to human experience. This contribution can be illustrated through an analysis of the tendency towards the “medicalization of medical anthropology” that characterizes Anglo-Saxon anthropology.

In the 1970s and 1980s, a certain passion for finding new places for complementarily between anthropology and epidemiology surfaced. The objective was to propose methods which allowed for the measurement of the prevalence of health problems, and particularly mental health, and to analyze their distribution through time and space. The epistemological issue had just found a middle-ground position between the universalist pretentions of occidental psychiatric nosographies and the documentation of culture-
bound syndromes which referred to sicknesses specific to certain cultures. In both cases (as in several other fields of application of health anthropology) the anthropologists associated with cultural factor specialists were encouraged to intervene to facilitate biomedical interventions, to improve the results, and to facilitate expansion. Evidently, criticism came swiftly from anthropologists who were sensitive to the ethical issues involved by such a collaboration. Several critics reminded the anthropologists that the concerns of the application of medical anthropology could not support the imperialist enterprise of biomedicine, which was as much cultural as economic, nor could it accept the folklorization or the marginalization of ethnomedicine. Nancy Schepper-Hughes, for example (1990: 192), called for a medical anthropology that must obligatorily "disengage itself with regards to medicine and demarcate itself from conventional biomedical interests". The issue here is that of the risk of anthropological biomedicalization, in particular in mental health, or more precisely, the risk of a subordination of the possible contribution of anthropology to the epistemological postulates and to the agenda of medicine.

Such a warning against the medicalization of anthropology was recently voiced by Carole Brower (1999), who perceives a strong tendency among anthropologists to retain biomedical entities conceptualized by medicine as objects of research. She sees in this a kind of anthropological acculturation, which she describes as "going native", that is, becoming "medical natives" by adopting the language and the scientific practices of biomedicine. The idea I am advancing here is that the risks of the medicalization of anthropology of health must be analyzed on two levels: first, at the epistemological level,
that is, at the level of the risks of empiricist deviation through the abuse of diagnostic categories in the definition of sickness, and second, at the methodological level, through recourse to qualitative methodologies borrowed from social science which tend to marginalize fieldwork.

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

A reading of recent issues of major medical anthropological journals, particularly Anglo-Saxon ones, attests to a certain withdrawal of anthropologists with regard to seeing illnesses as biomedical diagnostic entities. On the physical level, there is a plethora of articles dealing with respiratory and urinary troubles, cancer, menopause, AIDS and so on. At the mental health level, there are many papers dealing with Alzheimer, depression, schizophrenia, pre-menstrual syndrome or post-traumatic stress. These diseases are becoming the departure point for analyses aimed at identifying the cultural dimensions linked by each culture to these medical diagnostic entities. The risk in medicalizing anthropology is that of a research reorientation with regards to the diagnostic categories seen as reified nosographies delimitable and definable by means of symptomatologic configurations. From this standpoint, retaining “folk illnesses” or “culture-bound syndromes” as objects of research does not constitute an alternative to this empiricism drift. It simply exoticizes the perspective which confines psychological problems to reified categories (this time by means of popular knowledge), which are always defined according to somatic, affective, cognitive or behavioral manifestations.
In 1989, Mirowski and Ross had already severely criticized the use made by epidemiology, and psychiatry in particular, of diagnostic categories as in the case with the DSM (Diagnostic and Statistical Manual). They maintained that recourse to diagnostics such as mental health measurement tools hinders an in-depth comprehension of the manifestations and causes of psychological problems, namely because diagnostics do not take into account the structure of the relationships of causality which link the variables. This report groups the causes, symptoms, consequences and random associations between the symptoms into one shapeless mass (Mirowski and Ross, 1989:19). Byron Good (1992), for his part, criticizes the diagnostic categories for considering the disorderly categories as tangible and mutually exclusive discrete entities while disregarding all other logic regarding classification based on nuances and gradations according to the distress level and severity of symptoms or causes.

However, psychiatric anthropology's response to this risk of empiricist drift does not constitute a true epistemological break. Kleinman (1997) suggests that psychiatric anthropology should make a critical analysis of the nosographic classifications of universal pretensions. Furthermore, he recommends that psychiatric anthropology open itself to a "creolization" of psychiatric practices or to a "colonisation" of psychiatric diagnoses by way of an open discussion on cultural pluralism. The issue would therefore be to reaffirm the importance of "projecting the local amid the global while taking very seriously into consideration the local terms for disease identification" (Kleinman, 1997:75). Thus, to the extent that the focus is on the categorical classification of diseases, even if it is to integrate some local cultural components, in my opinion it is still a form of
subordination of anthropology to the epistemology and agenda of psychiatry. Although this objective is very commendable and most certainly inevitable, it must not sum up the essential components of anthropology to the analysis of mental illness.

From this same perspective, another path of major collaboration between anthropology and psychiatry is that of the promotion of sensitivity to DSM-IV with regards to the influence of culture on categorizations of mental “disorders”. In the introduction of Volume 35 (3) 1998 of the journal Transcultural Psychiatry, Laurence Kirmayer writes a rather negative assessment regarding the contributions of the “Culture and Diagnosis” working group. Although anthropological research can allow researchers to present popular parallel nosographies, and even local idioms, through which different peoples express and explain the numerous forms of mental health, those in charge of the fourth version of the DSM kept only the following elements in the final version: a brief commentary on the importance of culture, sections bearing on cultural considerations, age and gender which accompany the texts linked to certain psychiatric categories, an annexed glossary containing some 25 culturally conditioned syndromes, and a user’s guide for the formulation of the cultural conditions of a diagnosis.

The introduction of the summary volume for the DSM-IV did not take into account the suggestion aimed at integrating a definition of culture, race and ethnicity, nor the remark that the DSM itself was a cultural construction. No place was allotted for constructive criticism stating that the division into categories separated from somatoformic, affective, distress and dissociative disorders did not respect the natural co-variations of the forms of
distress observed in trans-cultural studies. Throughout the manual, culture is presented as a bias, capable of leading one to erroneous diagnoses, rather than a component of the definition of mental illness as a construction that is as much cultural as it is professional. The integration of an “Outline for Cultural Formulation” of psychiatric disorders became somewhat of a consolation prize. However, this guide was annexed to the whole and not placed directly after the introduction, to underline the importance of taking cultural and social contexts into account.

Evidently, communication between psychiatrists specializing in epidemiology and anthropologists required the sharing of a minimum of common language. This common language was that of empiricism, where all concerned looked for recurrent characteristics and patterns founded on reified symptoms. Here again, the risk for anthropologists could involve losing sight of what constitutes their originality and their strength, that is, the analysis of the cross-influence of individual, social and political contexts in the construction and experience of suffering. What risks being marginalized in such collaborations is an anthropology of the experience of suffering, individually lived but socially, politically and culturally built. In fact, the impetus of psychiatric anthropology over the last two decades was to criticize the validity of the diagnostic categories while epidemiology's task was to increase reliability. While the DSM working group papers aimed at assuring the internal coherence of the diagnostic definition's criteria (i.e., stability of factorial constructs of a social sub-group and of one culture to another), anthropology questioned the intra-cultural as well as the transcultural validity of such disease categories. But even this critical approach confirms anthropology's subordination
to the medical agenda. Paradoxically, it strengthens the epistemological paradigm it thinks
it is denouncing.

**Methodology and fieldwork**

On the methodological level, this medicalization of anthropology seems to be confirmed
by a trend in articles published in specialized journals, and is expressed either through
interviews – sometimes in conjunction with direct observations, but on
"decontextualized" sites such as operating rooms, or hospital emergency waiting rooms –
or through methodologies based exclusively on narratives of lived episodes of sickness.
In addition, in the 1980s, health practitioners called upon anthropologists to develop rapid
ethnographic assessment procedures to assist them in the collection of data related to
knowledge, beliefs and values about diseases. Generally, the absence of long-term
fieldwork can be noted, and the lack of integration of narratives into social and global
political contexts.

Nevertheless, the use of these new data analysis methodologies (such as iterative content
analysis, discourse analysis or grounded theory), as well as the increasing use of analytic
textual data software, represents a jump-start for anthropology. Not only do I personally
teach it to my students in anthropology, but I have also widely used these methods within
the framework of different research projects in Quebec. I consider that in making the
analytical steps more explicit and systematic, and the conclusion’s construction less
impressionistic, these methods and techniques contribute to reinforcing the validity and
the credibility of research in the anthropology of health. Far from renouncing these
methods, anthropology, like all the other social sciences, should draw inspiration from them. However, the price could be high. It once again implies the risk of losing sight of the global perspective which belongs to anthropology itself. In fact, the fundamental issue here is that of marginalization of the terrain of the anthropology of health. Englund and Leach state that the biggest threat to anthropology is not the problem of funding but "the factory conditions and audit practices which now structure the academic work" (Englund and Leach, 2000: 238), as well as the pressure to feed the proliferation of journals, book series and conferences. This does not fit with the reflection of "a slow and unpredictable activity by its very nature. [...] Under such conditions, the doctoral project is becoming the only period of sustained and long-term fieldwork in a scholarly career. Not surprisingly, perspectives which require a minimum of fieldwork, perspectives which demand instant ethnography to illustrate aspects of a metropolitan meta-narrative, hold increasing appeal" (Englund and Leach, 2000: 238-39). Hence the recourse to meta-narratives and vast theorizations of post-modernism serves as an alternative to a "realist reflective ethnography", which rests on shared experience and a real commitment of the researcher to local populations.

Two tendencies counterbalance this move towards the marginalization of the field and the decontextualization of analysis. First of all, Kleinman (1995) represents a return to an in-depth ethnography in medical anthropology publications. There have been more detailed monographies published in book form since the end of the 1980s than over the last 40 years. There seems to be a pendulum effect with regard to the publication of hundreds of essentially theoretical works. Kleinman (1995:194-197) sees in these ethnographic
monographs a challenge to the basic conventions in health research. Through their in-depth analysis, their concern for detail, and their sensitivity to the plurality of constructions of the significance of sickness, the ethnographic book presents an alternative situated in a no-man's land between science and the humanities. But first and foremost, the ethnographic book allows the most faithful representation possible of the phenomena marginalized by medicine, such as common knowledge, alternative practices, the phenomenological dimensions of the experience of the sickness, and the socio-political causes of sickness. Second, an important phenomenological current has developed since the beginning of the 1970s in Anglo-Saxon medical anthropology concerning the ethnography of suffering experience. This is an important counterbalance to the methodological drifting which could lead to the decontextualization of sickness from the biographic framework. In this last example, however, there is always the risk of confining the analysis of social and mental suffering to the micro level.

In the framework of my own research on psychological distress in Martinique and French Canada (Quebec), I had initially planned to produce diagnostic tools with a sensitivity to local idioms of identification, expression and explanation of mental suffering. This exercise could have been done from case studies of depressed patients, open interviews with sick people, or with people close to the patient, or even by filling out diagnostic charts to which we could have added a few "local" symptoms. However, each of these approaches restricts the analysis to a person outside of the context of the family, community and social surroundings in which he or she is evolving. Only a hands-on, long-term approach, built on observations in the different life surroundings where this
psychological distress develops, allows us to grasp the work of culture on suffering and to grasp the richness of meanings brought out by the local idioms used to describe distress. For example, the observation of constant tension between spouses, between parents and children, and between grandparents and grandchildren have confirmed that, while it is sometimes a nest of security and stability, the family environment is often the first place where stress, anxiety and frustrations erupt. An anthropology of depression cannot escape from an anthropology of the family and inter-family relationships, in societies marked by an accelerated destructuralization of the family unit and by the redefinition of gender relationships. Also, an anthropology of social suffering must take into consideration different mediatioral observation spaces. For example, political assemblies or unions are very interesting surroundings for analyzing the social and racial tensions that serve as a backdrop to a tense and frustrating climate. Small group meetings and prayer meetings organized by the members of fundamentalist churches, which take place in the homes of sick brothers and sisters, allow us to explain the importance of the church as a place for rebuilding lives and overcoming depression. Analysis of the pastor’s sermons allows us to understand the place that Satan and sin take in people’s explanation of sickness. It also allows us to understand the origin of a reinterpretation by many sick people of alcoholism, drug abuse, and also of dancing and sexual liberation, as demonic manifestations that bring on depression. Just as important are direct observations of suffering within the daily lives of unemployed people, as well as an analysis of what is conveyed in newspapers, radio, television, and political assemblies which can be grasped with a sustained fieldwork approach.
There is no need to prolong such a list with more examples for an audience of anthropologists. However, current pressure for an applied anthropology which is complementary to medicine carries a reminder of the importance of being sensitive to aspects of the social life of individuals on whose behalf anthropologists want to express themselves. The contributions of anthropology must go beyond the framework of a culturalization of diagnostic categories, be they popular or medical, in which will be disclosed different forms of expression of psychological distress.

**CONCLUSION**

This tendency to medicalize the anthropology of health is more significant in Anglo-Saxon countries than in France and in Europe in general. The reasons for this are complex. In the United States, Canada, and Australia in particular, not only has this sub-discipline been established since the beginning of the 1980s, but in the last two decades, several thousand graduates in medical anthropology have found jobs in government agencies, community health centres, multi-ethnic organizations, public health agencies, research centres in epidemiology, and insurance companies, far from the preoccupations of fundamental research. In no way do I believe that we must refute this tendency towards tangible and practical applications of anthropological knowledge to Health Care and to the management of health policies. Having myself worked for several years as an anthropologist within a government agency of public health, I can attest to the importance and the pertinence of such a contribution. However, it is clear that an Applied Medical Anthropology will not be able to keep its credibility unless it is systematically
nourished by sustained fieldwork which allows for an analysis of the interrelationship between diverse illness dimensions.

The search for zones of complementarity between, on the one hand, an anthropology of health and, on the other hand, epidemiology, medicine and psychiatry, must remain a major anthropological challenge in the decades to come. The acquisition of increased rigour in qualitative research methods, the development of a common epistemological vocabulary, and the search for common ground on a methodological level between these approaches is a necessary, but not sufficient, condition. Anthropology must, however, assume the responsibility that is radically marked out on an epistemological and ontological level, whether it is in regard to fundamental beliefs about the nature of the reality studied or in regard to the ultimate finality of the research (Massé 2000). In summary, this incommensurability exists between the finalities of comprehension versus the objectives of health measurement; between the objectives of reconstruction of the numerous layers of the meanings of suffering versus the objectives of producing culturally adapted definitions of illness categories which will serve as a springboard to comparative transcultural investigations; and between the objectives of meaning relocation in the numerous levels of context versus the objectives of delimiting diagnostic entities presenting transcontextual and transcultural validity. The anthropology of health will have to assume, without complexes and in a creative way, the incommensurability of ontological paradigms.
REFERENCES


