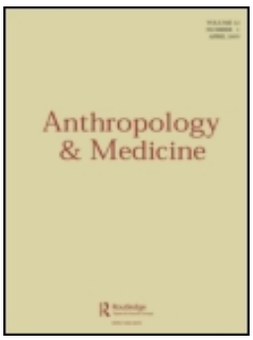

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INTRODUCTION TO PART II

Medical anthropology in Europe – *quo vadis?*

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In the 1960s and 1970s, European Universities were affected, if not enduringly transformed, by anti-hegemonic social movements, such as the feminist movement and women's liberation; the anti-psychiatry movements; the Prague Spring and the Spring in Paris of 1968; the Club of Rome's dire ecological prognosis; and the anti-nuclear, environmental, alternative medical, anarchist and other leftist ideas, which spurned intense discussion and, sometimes, action. The economies in Europe were thriving at the time, but there was a sense that the consumer society they engendered would not be enduring; social crisis was imminent, if it had not already affected some economies.

Social/cultural anthropology gained new impetus in these climates of higher education seeking for other modes of knowledge production than the bureaucratic ones institutionalised at universities. The anthropological field method was not reductionist but required full-time and long-term immersion in research that would not leave anyone personally unaffected. Its results, which were later reduced to being termed 'qualitative', implicitly critiqued undue reliance on numbers and statistics. Finally, its basic assumption that through the study of another society, one would become more self-aware and critical of one's own society, drew many a student in search of a better world.

The current topics ranging from 'the practice of care' to 'the body politic' and 'the psy-dimension of personhood', which are discussed in the second part of this special issue, owe perhaps more than is generally acknowledged to these social movements. In Europe, 'the practice of care' has been studied from many angles, and importantly also from a perspective that aims to overcome the somewhat artificial division between 'applied' and more 'theoretically-oriented' research often referred to. The focus on practice that it implies is best understood in light of 'the problem of knowledge', which was central to early discussions in the field. The second theme, on the 'body politic', owes much to the feminist movement, which uncovered gendered asymmetries and also led to a re-evaluation of the body (as the female counterpart to the male mind) by stressing the importance of researching the body as a cultural and socio-political project in the making. Finally, the anti-psychiatry movements, which

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highlighted the irrationality of the concept 'mental disease', engendered innovative medical anthropological research into 'the psy-dimension of personhood'.

Medical anthropology emerged as an academic field at a time when these social movements shook Europe. From these days emerged a concept of holism that, in place of the logical opposite, monism, became the catchall to overcome problems caused by an overly rationalistic outlook for which the dualist Cartesian framework was made responsible. Medical anthropology attracted many a student interested in other, non-Western, Amerindian or Far Eastern, shamanic or scholarly ways of doing medicine. The social, and at times Marxist, critique of one's own society was an important incentive.

The problem of knowledge

'The problem of knowledge' arises when one appreciates magical and medical knowledge and practice for their, if only partial, internal coherence and validity. It has been addressed from successively different angles – including, very roughly speaking, the ethno-sciences in the 1960s, the anthropology of knowledge in the 1970s, the sociology of knowledge in the 1980s, and Science and Technology Studies (STS) since the 1990s.

Ethnoscientific endeavours, which were often undertaken by linguists and/or psychologists, engendered the concept of an 'ethnomedicine' alongside ethnobotany and ethnozoology (e.g. Fabrega 1975). However, already the earliest articles that were to define the field of medical anthropology expressed doubts about any decontextualised taxonomy of knowledge. In the first issue of *Culture, Medicine and Psychiatry*, Good (1977) criticised Frake's (1961) classification of Subanun skin diseases for ordering knowledge taxonomically. Instead, he explained the 'heart distress' of women participating in a family planning project in semantic networks, thereby aiming to analyse medical knowledge as constitutive of societal workings at large. Furthermore, an anthropological analysis was not to over-systematise, a legacy in Europe strongly associated with Barth (1975), which has remained an issue of undiminished concern (e.g. Littlewood 2007).

During the heyday of the rationality debate, semantic networks and explanatory models (EMs) came out of Harvard, while in the UK Horton and Finnegan's (1974) *Modes of thought*, Gellner's (1974) *Legitimation of belief* and Needham's (1975) 'Polythetic classification', which all built on Evans-Pritchard's legacy, inspired research on illness causation, nosological categories and other 'systems' of knowledge and practice. But as these debates started to become polarised into either 'universalist' or 'relativist' claims, researchers were alienated. Instead they increasingly turned to practice theory.

Furthermore, it would appear that the critique of modernity, which is perhaps implicit in most anthropological studies of another society, became increasingly more explicit. It was fuelled by an othering of 'The other' and a self-critical stance edging on the self-destructive. By the 1990s, it had effected a shift towards critiquing modern scientific medicine in Europe and North America. This development in thematic orientation coincided with an increasing uncertainty about those economies; field research abroad was no longer always encouraged. The shift in focus from the clinic in the tropics to the laboratory next door put centre stage the sociology, rather than the anthropology, of knowledge. It began with a social

constructivist critique of science, highlighting the importance of practical tacit knowledge (Latour and Woolgar 1979), and deconstructed medicine as a monolithic enterprise (e.g. Berg and Mol 1998). Although neither of these insights were radically new, as evidenced by Polanyi (1958) and the authors in Part I of this volume, the framing of the inquiry was intriguing on both a methodological and theoretical level. It has since further accentuated the shift away from epistemologies to ontologies (e.g. Mol 2002) and spearheaded research into new socialities (e.g. Franklin 1997). Medical anthropologists from London to Vienna, Amsterdam to Edinburgh, and elsewhere, have drawn inspiration from STS and themselves become its drivers.

The practice of care

Just as competence and care have been singled out as defining an inherent tension in medicine, this distinction may apply also to medical anthropologists; one could characterise those with a penchant to STS as engaging with medicine's claim to competence, while others, often equally dedicated to a social critique of science and society, have undertaken research into what is here termed 'the practice of care'. Care is here understood in a broader sense than in medicine, where it encompasses general practice, the caring professions and home-based medicine. Medical anthropologists have long gone beyond medical sociology's concern with the patient-practitioner dyad and have linked the sociology of situated knowledge production to situated caring practices as an aspect of sociality more generally

In Europe, early work into the practice of care centred on migration and health, a topic that trans-cultural psychiatry had earlier addressed in its narrower formulation of migration and mental health. The concept 'culture-bound syndrome' is a legacy from trans-cultural psychiatry that even today has not yet been entirely buried, as it resurfaces in undergraduate essays and colleagues' well-meaning comments. Medical anthropologists, however, have long discarded this concept from their analytic toolkit, not least as it medicalises unusual forms of conduct and thereby exoticises other peoples and 'ethnic' immigrants. Early criticisms (e.g. van Dijk 1998 [1989]) have more recently been reconceptualised and reformulated (e.g. Fassin 2000) and generalized into a critique of culturalism (e.g. Olivier de Sardan 1999). Yet, as Fainzang (2007 [2005]) notes, one need not do away with the concept of culture entirely, as this concept encompasses historical and political dynamics that cannot be ignored even in the study of micro-social settings such as the clinical encounter. The increasing mobility of labour forces into and within the European Union has kept the theme of migration as relevant as ever (e.g. Hüwelmeier and Krause 2011), also in studies on other continents (Napolitano 2003), while research into mental health has since seen many turns in theoretical orientation, of which one only will be discussed below.

The practice of care has also been a longstanding concern for medical anthropologists working in the context of development studies, which in Europe often involves Africa. It has been researched within the anthropology of pharmaceuticals, hospital ethnographies, patient agency, and the like, sometimes in close collaboration with South-Saharan colleagues (e.g. Van der Geest and Whyte 1988; Whyte, van der Geest, and Hardon 2003). The formulation of social pragmatism has gained distinctiveness, particularly in Copenhagen (e.g. Whyte 1997), but not exclusively (e.g. Benoist 1996; Geissler and Prince 2010). Research

within this social pragmatic framework warrants long-term fieldwork, such as yearly returns to one's second home in Africa over decades. It is this sort of research that can account for the increasing problem of chronic conditions in ethnographies that holistically present the villagers' daily life (see Whyte, this issue).

The practice of care has also been of primary importance for research on AIDS, which, as Mattes (this issue) demonstrates, has steadily been integrating new research agendas. Where research into sexual networks and the prevention of HIV infection marked the early days, research now centres on anti-retroviral treatment, the social inequalities that access to it generates and upholds, and moral issues ensuing from the chronic nature of the condition. Although medical anthropologists became involved in this theme later than epidemiologists, whose concept of risk was instantly contested (e.g. Frankenberg 1993), concerns relating to the care of AIDS in a world of increasing uncertainty and risk have left a lasting mark in the field (e.g. Dilger and Luig 2010).

Finally, the practice of care has pre-occupied researchers who responded creatively to the era of postmodernism by initiating ethnographic research at home in urban and modern settings (e.g. Fainzang 2000 [1989]; van Dongen 2004), at a time when elsewhere it engendered excessive navel gazing. Medical anthropology at home, MAAH, constitutes perhaps one of the most distinctively European endeavours. This is said in awareness that the association's members pursue diverse research interests. Historically, medical anthropology evolved in close association with folklore studies in Italy and Spain (e.g. Sepilli, this issue; Comelles 1996), much in contrast to France and German-speaking countries, and arguably Lithuania, Latvia and Finland (Vaskilampi 1994), where social/cultural anthropologists and folklorists have tended to maintain a guarded distance. Some MAAH members have since adopted a more political economic perspective, others a distinct pragmatic stance, and yet others combine an STS analysis within controversies over citizenship, in the light of the increasingly legalistic developments of health care.

From the body politic to the body

The 'body politic', rather than the body, has been central to medical anthropology since the early days. Witchcraft, spirit possession and childbirth, themes that typically concerned women, tended to be analysed in view of gendered power relations within the body politic, although the authors themselves did not use the term. To be sure, witchcraft and spirit possession were used to frame social processes in ways that medical anthropologists contested, by highlighting either that people's health concerns are generally not as exotic as supposed (see previous section on social pragmatism) or that the plight experienced by every bewitched is actually a quite common human condition (see next section on phenomenology). Witchcraft suspicions are often directed at women, as in the currently rampant killings among the Sukuma (Mesaki 2009) – often women to whom men are vitally indebted, e.g. the paternal aunts, whose departure into another lineage provides the men the cattle they depend on for founding a homestead (Stroeken 2010: 145).

Likewise, it is through a medical anthropological lens, combined with a grounding in gender studies, by which I.M. Lewis' functionalist explanation of so-called peripheral 'spirit possession' as a socially disregarded, hidden, mostly female practice, has been revised. Well-known is Boddy's (1989) compelling

ethnography on women's life worlds and the intricate interdependencies of the segregated gendered spaces in the Sudan, but it often goes unacknowledged that De Martino (2005 [1961]) had earlier brought phenomenology into the analysis of spirit possession in the tarantula dance of southern Italy. De Martino focused on how the religious experiences of the politically subaltern interrelated with their historically grown socio-economic condition (see Pandolfi and Bibeau 2007 [2005]: 127–8), while the gender dimension has since been foregrounded, particularly in studies that bring the body political into focus (e.g. Behrend and Luig 1999; van Dijk, Ries, and Spierenburg 2000).

While spirit possession generally has been discussed in the anthropology of religion (e.g. Sax 2002; Gellner 1994), it has increasingly become a topic of medical anthropological research, as spirit possession practices have been peculiarly resistant to the encroachment of medical professionals in pluralist health fields. In this volume, for example, Bindi accounts for the body political through a focus on the bodily experience of becoming possessed. Bindi thereby expands on Pandolfi's early work (e.g. 1991), which started with narrative analyses but led on to an account of embodied memory and emotion, and is exemplary in illustrating how the medical anthropological concern with the 'body political' has increasingly shifted to the 'embodied political', and thereby to an increased focus on the body.

Finally, the early research on midwifery and birthing can also be appreciated as research into the gendered body politic, although initially it was not expressed in those words. Early literature on childbirth often combined a xenophilia for other peoples with a critical view on medicalised practices in North America and Europe. It was often biomedical professionals who took other people's practices as a source of inspiration to effect a change in modern medical birthing facilities and to instil a renewed appreciation of the homebirth. It appears that precisely this heterotopic literature on childbirth has put women in industrialised countries under additional stress and, particularly in cases of complications, aggravated self-doubt (Kneuper 2003). More recent literatures emphasize that providing adequate maternity services remains a body political issue, not merely in the Southern hemisphere (e.g. Unnithan 2004), but also in Eastern Europe (Putnina 1999).

Witchcraft, spirit possession and childbirth thus all bring into focus the cross-culturally observed precarious position of women. Research into the body politic has since become more diverse, whereby globalization, medico-scapes, the pharma-industrial complex, substance abuse, and violence are discussed alongside medicine as affected by nationalism and the moral economies of ethnicity (e.g. Samuelsen and Steffen 2004; Lambert and McDonald 2009; Ecks and Harper in press).

Where medical anthropology in its early days emphasized that medical problems were not primarily to be found in the body but in the social, one can observe a re-appraisal of the empiricist's biological body in *Beyond the body proper* (Lock and Farquhar 2007): a social critique need not imply disregard for any bio-scientific findings. The dissected, dead and static body that social scientists know as the biomedical one is only one of the many described in the bio-sciences, where research on living bodies ranges from the study of electro-communicative fibres of the connective tissue to the ecologies of diverse genomic micro-organismic populations of the gut. However, some medical anthropologists have gone yet another step further by highlighting that the biological body as a fine-tuned project-in-the-making implicates the body political.

Where Bindi (this issue) highlights how the body politic of competing medical treatment choices is experienced in the individual bodies of patients, Pizza (this issue) studies how the (non-)collaboration of diverse medical specialists, and their body political pre-occupation with trying to save time, leads to an increased likelihood of diagnoses of one of the most feared bodily conditions, dementia due to Alzheimer's. Gramsci's notion of 'second nature', which Pizza explains in a very accessible prose, allows for a micro-social, or what Gramsci calls a 'molecular' analysis, which simultaneously accounts for the bodily and body political. In his analysis of how early diagnoses of Alzheimer's are produced, Pizza makes the Gramscian concept of 'second nature' appear less disembodied than Bourdieu's concept of habitus and also less deterministic than a Foucauldian inscription of the state on the individual. 'Second nature's' constant reworking forfeits social determinism: in endlessly many minute micro-social situations, it allows the actors to have self-reflection, and to rework it accordingly.

The psy-dimension, the senses, emotions and aesthetics

The *Anthropology of the body* was edited by an ethnomusicologist (Blacking 1977a) and, therefore, has not generally been on introductory reading lists of medical anthropology.[1] It discusses human activities that are bodily in yet another way: from a social anthropological perspective that does not disregard biological anthropological considerations entirely.[2] It asks, for instance, how making chamber music can generate moments that are emotionally extremely rewarding, as for instance moments when the individual experiences a dissolution in sound and a melding with the group as a whole (Blacking 1977b). Blacking's perspective takes as its starting point group-coordinated human activity that is aesthetically pleasing and links it to bodily, sensorial and emotionally-felt processes of sociality. His approach meets well with the current medical anthropological interest in the bodily. In contrast to the empiricist scientist's gaze onto an individual's bounded biological body-enveloped-by-skin, the focus is on people's aesthetically pleasing experiences of bodily interaction within a group.

Medical anthropologists have variously drawn on insights from symbolic anthropology, psychological anthropology and ethno-psychoanalysis, but it would appear that the most important source of intellectual stimulation on the illness-generating social processes, within which the emotional is inflected, comes from yet another direction both in early and current medical anthropological research. This is phenomenology. Today, medical anthropologists on both sides of the Atlantic draw on Merleau-Ponty, whom Thomas Csordas (e.g. Csordas 2002) put centre stage within the field, importantly, by including Bourdieu's concept of the *habitus* into the discussion of the pre-objective. However, many thinkers had propelled this philosophical movement already in the first part of the last century (among them the above-mentioned Ernesto de Martino). Phenomenology also inspired many physicians who initiated foundational research for medical anthropology. Among them are Franco Basaglia (1924–1981), whose achievements within the Italian anti-psychiatry movement transcended national boundaries (Pandolfi and Bibeau 2007 [2005]: 124–7), as well as F.J.J. Buytendijk in the Netherlands and Joachim Sterly in German-speaking countries (mentioned in the introductory essays), and it continues

to guide medical doctors' anthropological explorations (e.g. Martínez-Hernáez 2000).

The contributions to this volume by René Devisch and his former student Koen Stroeken both take a phenomenological approach: Devisch to divinatory practices among the Yaka in Zaire, Stroeken to witchcraft accusations among the Sukuma in Tanzania. Yet each engages with phenomenology in a different way: Devisch emphasizes the matrixial and attends to symbols relevant to psycho-analytical reflection, while Stroeken's phenomenology insists on the validity of empirical observation, particularly among rural 'peasant intellectuals.'

Stroeken's paper also contains an interesting side note, which is that the emotional is often manipulated by the botanical. It is interesting that in the context of exploring the psy-dimension and aesthetics that ethnobotanical research resurfaces as relevant, as it has the potential to assist medical anthropologists in better understanding therapeutic techniques of emotional manipulation and modulation. As Stroeken (2010: 26) notes elsewhere, the plant mixtures that healers administer to their clientele always involve one plant acting as a connector, which may trigger a sensory shift that brings with it a transformation of the patient's emotional states. The plant that is credited with effectiveness typically is a fresh and often aromatic plant (on the connection between scent and sacred, see Lefevre, Randriahasipara, and Velonandro 2008: 103). Scent has a certain physicality (Parkin 2008), and not only the meanings it evokes but its very physicality is likely to affect the physicality of the emotional.

There is an unexamined, yet nevertheless widely accepted, assumption that empirical knowledge derives from indiscriminate experimentation in terms of trial and error. Recent phenomenologically-oriented research points to more intelligent bodies that are primarily practical, that, when they project themselves with intentionality into the world, have the ability and propensity to learn from and test the world in non-random ways. These approaches integrate the psy-dimension into the internal bodily-felt as well as into observable human interaction. They thereby aim to overcome the constructed division of the subjective from the objective. Just as it is important to locate the sensorial not in the person but in the interpersonal interrelation (Chau 2008), the emotional is best conceived as a process that arises in the interrelational.

A focus on the physicality of the emotional in human interaction, which Devisch does in all his writings, rather than speculating about the individual's interiority, calls for a paradigm shift. Devisch reminds us that the psy-dimension can only be comprehended by doing away with the artificiality of studying either semantics (meaning/knowledge) or pragmatics (doing/action).

Accordingly, the Word and the World are not as separate as social and natural scientists currently construct them to be. Latour (2000) speaks of a 'realistic realist' stance (with interesting implications for medical anthropology, see Hsu 2010). A realistic realist's ethnographic fieldwork of individually-felt, emotionally-rewarding, coordinated human interaction, with a focus on its processual aspects, is likely to transcend the limitations of actor-network theory that arise from locating agency in the actor instead of the interaction. Perhaps, such a medical anthropologist's realistic realist's perspective has the potential to make important inroads towards a more general anthropological understanding of the psy-dimension as it resonates with social and other environmental workings.

By way of conclusion

The practice of care – at home and in developing contexts, in applied and less applied settings – is certainly one of the core themes researched in Europe. The focus on practice (and knowledge as an aspect of practice) is probably best explained in light of the centrality that practice theory has enjoyed in social anthropology. The focus on care – in its broadest sense – reflects, no doubt, a critical stance, which many medical anthropologists share, towards impersonal, confidence-diminishing, disempowering, if not illness-inducing medical care in bureaucratic institutions.

The sections on the body politic and the psy-dimension highlighted the field's debt to anti-hegemonic social movements, such as the feminist and the anti-psychiatry movements. As the section about the body politic shows, the social practices that in anthropology are discussed under the rubrics of witchcraft, spirit possession and childbirth have much enhanced our understanding of the precarious position of women in many societies. In a similar vein, the phenomenological documentation of how bodies are experienced in aesthetically coordinated interaction promises to provide a fruitful mode of appreciating the psy-dimension and render obsolete excessive reliance on often surprisingly ethnocentric speculations about an individual's 'psychology'. Medical anthropological research of this kind, which acknowledges the debt to the Cartesianism built into our thinking but simultaneously engages in field-based inquiries that relativise this dichotomy, is likely to provide a framing of general relevance for future research that may transcend its disciplinary foundations.

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Conflict of interest: none.

Notes

1. This is so although Murray Last, Gilbert Lewis and Vieda Skultans have a paper in this ASA volume, as they do in Loudon (1976) and Littlewood (2007).
2. For a more recent, similarly creative attempt to overcome the widespread 'aversion' among medical anthropologists against biological anthropology, see Parkin and Ulijaszek (2007).

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