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Introduzione/Introduction

THEORETICAL APPROACHES AND KEY CONCEPTS IN MEDICAL ANTHROPOLOGY

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SUMMARY

The theoretical views and ideas offered in the following pages – which are quite long in order to offer a through explanation of the vast and diverse medical and anthropological literature we have available – regard specific concepts and paradigms that will be useful in order to create a solid framework for the ethnographic material we have gathered.

For more than twenty years, within a medical-anthropological debate, the notions of the body, health, and disease have been the subject of a fundamental redefining process, freeing these notions of assumptions regarding "natural" realities, while highlighting cultural, social and historical modalities that subtend their makeup. Ethnographic research, through the comparison of how the body, health, and disease are represented in various groups, has shown just how variable corporeity – and the threshold that separates health and disease – is in different cultures. The concept of corporeity is defined by a fundamental ambiguity: on one hand we have the experience of the body itself, while on the other there is the objectification of the biological body and how it is represented.

Key words: Medical Anthropology - Theoretical approaches

When making the distinction between experience and representation of the body, the subject of our anthropological and philosophical debate, we are unable to find a clear connection to real life. As a matter of fact, we find ourselves with a body to represent, and yet at the same time, these are the bodies through which we know the world around us. Such a dichotomy is a "pretence" that arises within a Cartesian philosophical-scientific system and the mind-body dualism that has permeated Western science – a paradigm in which the human subject is conceived solely as a thinking being, while the body is simply a physical instrument, completely detached from thought. The distinction between *res extensa* (a physical substance that can be measured and divided) and *res cogitans* (heavy substance and as such cannot be measured or divided) is at the foundation of the aforesaid dualism that sees the body and mind at independent entities than are not conditioned by one another[1].

Beginning with Descartes, Western philosophical thinking regarding mankind has generally developed on a theoretical level and not on the basis of actual historical and social experience. Western science has welcomed the Cartesian dualism while denying those contradictions that oppose the philosophical theory rather than daily practice. Even anthropological thinking has long been dependent on this dualistic conception, which gave rise to the process of multiple dichotomies, expressed through the contrast among "We", the "spiritual" West, and "Them", the "wild" and "material" Non-West. As a result, we find a clear break between the corporeal experience in "mental" and "Cartesian" Europe, with that of an experience an "exotic" and "psychosomatic" corporeality in which the Western separation had not yet been produced[2].

Since the thirties, the theme of the body has become the subject of studies in the field of humanities through the development of the concept of "Techniques of the Body" by Marcel Mauss, who defines this concept as follows: "The ways in which men, from society to

society, men know how to use their bodies"[3]. The body is mankind's first tool, through which we interact within the fields of culture, society and history. Starting at this moment, in which the body exceeds its mere biomedical definition, anthropological studies address the ways in which social processes and cultural forms act on the body and therefore on the biological aspects of the human being. In this sense, technique is a form of learning that reflects the specific context in which it arose, becoming natural to the point of appearing as a practice belonging to biology rather than socio-cultural orders.

If the body technique varies based on the contexts in which it develops, it is therefore possible to investigate the nature of what Mauss defines as *habitus*[4]. With this concept, the author indicates all daily practices – such as sleeping, eating, talking, gesticulating etc. – that, while apparently "natural", are actually culturally learned in ways that may not be based on verbal communication. In many cases, this can be "silent" learning[5], absorbed by the body through observation and imitation in ways that do not require an explanation. In this sense, the positioning of the body in the world – posture – are body techniques and the product of the cultural modelling that takes place as part of the relational experience, camouflaged processes that are triggered when we interact.

The notion of *habitus* led to a recognition of the body as the result of an extensive social and cultural process, and contemporary anthropological thinking, through the elaboration of the concept of *embodiment*, has made fundamental progress towards the deconstruction of the scientific paradigm founded on the Cartesian dichotomy. This concept, which has become the central point, defines "the ways in which humans experience the body in the world and produce its representation" and refers to "the historical process of construction of the corporeity and bodily ways in history"[6]. This concept considers the experience and representation of the body as inseparable: it is the body that experiences the world and, at the same time, produces

representations that arise from this understanding in the broadest sense of the cultural production of itself and the natural and social reality. The subject and the object of representation and experience are therefore inseparable – embodiment is, in this sense, the human condition, which appears mystified, due to the effect of naturalization that the body itself inevitably produces because it arises from the imagination of reality, therefore tending to be naturalized.
The concept of embodiment in contemporary anthropology takes on the role of a methodological principle: Thomas Csordas, in an article published in 1990, regards it as a paradigm for anthropology[7]. The embodiment theory has contributed to a major revamping of the discipline, taken on as the new theoretical perspective to be used to investigate cultural forms and the ways in which the Cartesian mind-body dichotomy is expressed. From the reinterpretation of the concept of embodiment developed by Maurice Merleau-Ponty and Pierre Bourdieu[8], and through the analysis of specific ritual practices of the Christian charismatic movements, Csordas elaborates what he calls "cultural phenomenology", in which the body takes the value of "subject" of the culture:

> *The approach I will develop from the perspective of psychological anthropology leans strongly in the direction of phenomenology. This approach to embodiment begins from the methodological postulate that the body is not an object to be studied in relation to culture, but is to be considered as the subject of culture, or in other words as the existential ground of culture*[9].

Therefore, the body is the starting point for the analysis of the culture and the self. B By analyzing perception and practice (*habitus*), there is the collapse of the distinction between subject and object - it then becomes possible to investigate the experiences and representations as constituting a continuous corporeality process. In this sense, historical, social and cultural processes are body products – namely cultural and natural – and the result is the embodiment of the exter-

nal actions and forces, as well as the objectification of our bodily experiences; "The body therefore becomes a product of history, and history can be viewed as a bodily process"[10]. The subject's ability to act – and thus exercise power over others – passes through the body, through which power relations are expressed.

Csordas' analysis served as the basis for more recent studies on the concept of embodiment in medical anthropology, through which we began to look at the concepts of body, health and disease as a form of knowledge embodiment, based on the perception of historical, social, cultural and political realities. Anthropological work, which took on the basic principles of this phenomenological tradition, has had the merit of assaying biomedical classifications related to health and disease, revealing these as various cultural products, configured within corresponding frameworks of the mind/body dualism. For the French philosopher, the origin of everything is the body: a system in relationship with the world and that perceives the world. Perception does not lie in the external stimuli that the body would passively register; rather it is in the body and is indeterminate until it encounters an object. This is based on the idea that before the sentient body, there is no object, and nothing can be grasped objectively regardless of an operation of objectification-perceptual abstraction that is already culturally organized. A body in the world is abstracted and represented, gives meaning to the indeterminacy of the world by projecting its consciousness towards cultural interpretation of the surrounding reality. The body can only perform these operations in accordance with cultural values and manners, through which it aims its perception into the uncertainty – in itself meaningless – that surrounds it. The body as a subject of culture is agent at the same time acted upon, due to the fact that it is the object of cultural systems that guide perception. Bourdieu, determined to overcome the analysis of social systems, leads the reader towards a discussion that start with a concept of *habitus*[11], for which Csordas offered the following definition:

> *A system of perjuring dispositions which is the unconscious, collectively inculcated principal for the generation and structuring of practices and representations*[12].

A socially shaped body in every sense internalizes and embodies *habitus*. However, in addition to being culturally structured, the body in turn becomes a part of cultural structure – bodies that cultures produce are the same bodies that live in the world producing culture, practicing it and recreating it in a subjective manner. Introjecting means turning knowhow and skills into something that is your own, up to assimilation – capacities that become productive. The process of embodiment of the experience is related to processes from the body and of the body, the processing of social life and cultural production. From the body as the subject, we see it as the active producer of knowledge, and the body in fact as a product of social, cultural and historical dynamics, regarding hegemonic practices rooted in everyone's life and in the biographies of each and every one of us, receding from the sphere of awareness, moving towards unquestioned common sense. The arbitrariness of social life from culture becomes nature, shaping corporeality and turning into hegemony.
In this regard, the work of Nancy Scheper-Hughes and Margaret Lock is truly important. In an essay from 1987[13], the authors make a careful critique of the Cartesian dichotomy as "cultural model" to which they held that the same medical anthropology has long been subordinate. The task of medical anthropology is therefore that of revealing the historical and cultural nature of mind/body separation, which has managed to rise to a universal category by virtue of its "natural" definition. The body is in fact simultaneously natural and cultural, meaning that it is part of a specific historical context; therefore we can define it as a "thinking body"[14]. Based on this phenomenological interpretative perspective, we can reach the relationship between what the two scholars indicate as the "three bodies": the in-

dividual body, the social body and the political body. The individual body is that which the person experiences, meaning "in the phenomenological sense of body-self" as a set of its constituent parts (mind, matter, psyche, self). This was categorized in Western epistemology through the opposition of the individual and society, according to a concept of the self that is highly individualized, theorized as universal, but which, however, is not accepted by many groups.

Anthropological research has shown how well the Eurocentric conception of a unitary self, based on individuality, according to a Western philosophical tradition of where Descartes is considered one of the leaders, is not universal. The individual body must therefore be considered in relation to the social body, which refers to the means by which man thinks and represents nature, society and culture, and the political body, which refers to the powers and social forces that guard bodies, both individual and collective, in all areas related to reproduction, sexuality, work, health and disease. Mediation between the three dimensions of the body is through emotions, which represent a bridge between the individual, society and the political body, as they imply at the same time feeling and cognitive guidelines, a public morality, as well as ideology. The model of the three bodies therefore helps expose the artificiality of Cartesian dualism, on which Western science and clinical medicine are founded, allowing for the pursuit of a sort of radically materialistic thinking tied to a mechanistic view of the body and its functions.

The paradigm to which medical knowledge makes reference is built, in fact, based on biology – diseases reside in the physical body and they are biological and universal entities that transcend the social and cultural context. This "model" is defined by Byron Good:

> *The dominant medical model employed in contemporary medical research and clinical practice is grounded an empiricist theory of language. Diseases are conceived as universal biological or psychophysiological entities,*

> *resulting from somatic lesions or dysfunctions. Somatic or biochemical disorders produce experiences of distress and suffering that are communicated as complaints, and physiological and behavioural abnormalities that may be measured by clinical, laboratory or psychometric procedures*[15].

Biomedicine does not take under its jurisdiction that which is not an objective pathological condition, however there is a contradiction in this practical work when this field bases much of its diagnosis on the narratives and experiences of the patient, their symptoms. Medical science has in this way made a distinction among the signs, objective evidence of an illness amenable to direct or indirect observation, and symptoms or subjective evidence of a disease as perceived by the patient. From an anthropological point of view, the symptom is the narrative of an experience of suffering, rich in symbolism and socio-cultural references, because it was built by the patient starting from the embodiment of one's life experience. In light of the concept of embodiment, the distinctive sign/symptom is the revival of the Cartesian dichotomy in the objective/subjective opposition.
Medical anthropology claims, on the contrary, that the basis of the disease in the world's cultural significance and negates the claim to quantify its nature through its testing of organismic reductionism of biomedicine. The notion of embodiment makes it possible to analyze the relationships between human suffering and social relationships and power: the body moves in a network of power relations that define healthy or ill, according undeniable authorities of medical science. Just think of the classifications produced by big powers – such as the State, the Church and biomedicine – which, claiming a unitary forms of physical identity, legitimized and even violent acts of persecution against those who are distanced by these aforesaid powers, therefore establishing the threshold between normality and abnormality. Exemplary in this regard are the cases of witchcraft or hysteria, in which the distance from that identity has been considered a deviant, i.e. a mental disorder. State, Church and biomedi-

cine have thus taken an important role in the definition of normal and abnormal; with the common interest in controlling the female corporeality and with this the internal social body. The concepts of health and illness, quite far from being regarded as objective facts, now take on a different meaning when viewed from the perspective of embodiment.

Based on these assumptions, anthropological debate has questioned the concept of disease. M. Augé, in one of the most famous and profitable studies on contemporary medical anthropology, defines disease as "elemental form of the event"[16]. With this term he refers to all those biological individual events whose interpretation, imposed by the cultural model, is immediately social. With this in mind, birth, death and disease are elementary events because they are individual and collective at the same time. Disease is subject to the paradox of being both "the most individual and the most social events:

> *The paradox is made up of the fact that disease is at the same time the most individual and the most social of events. Each of us experiences it on his or her own body and may die. Feeling it ominously grow within themselves, an individual can feel a sense of detachment from others in everything that constituted their previous social life. Yet, everything in it is at the same time social, not only because a number of institutions take charge of the various stages of its evolution, but also because the thought patterns that allow you to identify it, to give it a name and to cure it, are eminently social: thinking about your illness means already making reference to others*[17].
>
> *Disease makes the link between individual perception and social symbolism explicit; this relationship needs to be explored in the intersection of its components, taking into account those that Augé says are the common foundations of the disease developed in all societies: 1) they speak of the individual (its definition, its components, its destiny, its accidents); 2) they speak of the society (the social causes of the disease, the threat they pose to the values and social situations structurally in terms of heritage, affiliation, affinity ...); 3) are based in part on observed facts: symptoms and circumstances of the illness*[18].

Disease, as a social aspect, is thought of as a representation, or as a production that refers not only to thoughts and words but also to behaviour of a particular group[19]. The quest for meaning that this creates in the subject or person requires that he or she were to give an explanation built using different reference systems, which vary depending on the context in which the event of illness occurs. To build the chain of causation in which to classify the disease, the person then draws on the social meanings connected with it, showing its links with institutions that go well beyond those that are connected to medicine.

Analysis of disease as an elementary event must take into account some factors that influence interpretation: the existence of a social order already thought out and defined, symbolized and set up prior to the event; the arbitrary nature of the event and the autonomy of the series of events in relation to the institutions that seek to understand and master them; as well as symbolic patterns underlying these interpretations.

Health and disease are not so simple physiological states, but rather conceptual figures that respond to instances of definitions that are culturally and socially determined, and which vary according to the geographical and historical context in which they develop. The same diseased condition is not objectively given, rather it is a status resulting from the explicit recognition by the community of a condition to which they give meanings commonly recognized by the community, and that the person lives with discomfort and malaise. The different diseases identified by medical science are not automatically perceived as such by those affected by the disease or the group to which it belongs. Ethnographic research has shown how the concepts of health and illness are not objective data that are mutually exclusive. On the contrary, there are categories whose boundaries fade according to historical time and geographical context, thus encroaching upon each biomedical definition. Health and disease processes are historical, cultural and socio-political concepts that try to enter

the real experience of the living body in an abstract representation, which responds to moments that are culturally defined and socially determined. They cannot be separated from the collective fields and the historical forces that actively intervene in their construction.
In an attempt to restore the complexity of such concepts, the term "disease" has been questioned, in a thought process aimed at renaming the phenomenon through the deconstruction of biomedical designations. The anthropology of the English language, especially the US, has adopted three terms to define three distinct dimensions of the disease: illness, disease, and sickness. The term *illness* can be translated in Italian with "malessere" and refers to the subjective experience of disease, the state of suffering as perceived by the subject; *disease* translates in Italian with the word "infermità" and identifies the biomedical definition of disease, the pathological condition objectified as an alteration of the body according to signs and symptoms. On the other hand, *sickness* is translated as the "state of disease" that is socially recognized: "the social role of the patient formalized at the time of diagnosis"[20].
Through this breakdown, we are then able to highlight the semantic complexity of the concept of disease, while also revealing the contradictions inherent in a definition that is solely biomedical. There may be a disease without illness or, conversely, an illness without disease – these dimensions may be different, but even overlapping.
From this tripartite division, anthropological approaches have created a thriving production – great importance must be given to current studies that focus specifically on the opposition of *illness/disease*. In this context, a major role has been that of scholars from Harvard University who have carried out a dialogical and interpretative study on the various narrative forms, which focuses on the subjective perception of the experience of illness. This approach, known as *meaning-centered*, was introduced by Arthur Kleinman in the seventies, and Byron Good was known among its best-known exponents.

At the center of their work, there is the *illness*, which is expressed through these narratives, designed as "cultural tools that aim to reconstruct the irregular experiences of illness in an order of meaning"[21]. The goal is to distance the disease from the definition given in biomedicine in order to highlight the cultural dimension inherent to it. Narratives are one of the tools available to the subject in order to meet the need for sense that the onset of disease creates – illness carries out a modification of the *habitus* and activates the need to represent the disease in a way that can be communicated – in order to define the experience in a meaningful order. This approach, while denaturalizing disease and highlighting the cultural dimension, also turned out in many ways to be a debasement. Narratives do not bring into play only the individual dimension of the illness, but there is a connected web of other dimensions, such as those related to social, economic and political relations, as well as the historical processes. The breakdown of terminology has been the subject of strong criticism by the French anthropologist Andras Zempléni[22], who considers this terminology subordinate to the notion of biomedical disease as a debasement – disease has a variety of aspects that are impossible to categorize in only three dimensions; doing so will also create the risk of not detecting the interaction between the three orders, those found in between, and many others. Important criticisms in the anthropology of *illness* are found in the work of Ronald Frankenberg[23] and Allan Young[24], who challenge the lack of consideration given to the processes of historical construction of biomedical categories of disease, the benefit of the exclusive attention individual experience of the illness, in an approach that is essentially clinical. They therefore propose greater attention to processes of disease formation and the socio-political and historical causes on which categories of biomedical disease are built. On the other hand, importance must also be given to the sickness as a process of socialization of illness as well as disease. In this way, the medical anthropology of disease

and sickness is developed, through which the limited space of the doctor-patient relationship opens up to a more complex reality of relationships and each therapeutic act is to be considered as a power confrontation that is played out in the complex socio-political field of power relations[25].

Following the review of the tripartite division of the concept of disease, two main theoretical currents were defined. On the one hand, the *meaning-centered* approach, whose members, once again A. Kleinman and B.J. Good, propose an observation of disease as a cultural construction of meaning, through the adoption of a hermeneutic perspective. This thesis is based on the concept of explanatory models, which Kleinman calls "belief patterns that contain explanations of some or each of these five questions: etiology, early symptoms, pathophysiology, course of the disease (severity and type of role of the sick person), and therapy"[26]. This concept refers to a set of terms used by those involved in the therapeutic process - patients, doctors, family members – to reconstruct the causes and meaning of an episode of illness and develop useful knowledge for the therapeutic action. We are dealing with models of knowhow and understanding that are set up in models of explanations, able to reconstruct the meaning and causes of the disease and that belong to both the patient and the doctor. The explanatory model of the patient and their family is founded on informal knowledge about the disease, in relation to strong emotions that guide those choices regarding the therapeutic route to take. The biomedical explanatory model, however, is based on the disease and combines knowledge acquired during training with those resulting from the therapeutic practice. The clinical reality of the care relationship is established through negotiation of explanatory models that are individual, family, professional or "traditional", all involved in relationship among the therapist-patient-family, making the transaction a therapeutic phenomenon of hermeneutic nature. According to anthropologists

of the Harvard School, conflicts in medical communication would be the leading cause of non-compliance and therefore of therapeutic inefficacy. Biomedicine should deal with curing ailments and not reprocessing experiences, therefore avoiding the need for patients to give meaning to their experience.
The "explanatory model" is to be found in a "semantic networks illness", a concept introduced in 1977 by B. J. Good during ethnographic research on epilepsy in Iran. This term indicates:

> *A "syndrome" of specific experiences, a set of words, situations and feelings that typically "contribute" to the members of a society, those symptoms and emotions through which the sufferer gives meaning to their disease. This syndrome is not only a reflection of symptoms linked in natural reality, but a set of experiences associated through networks of meaning and social interactions within a society*[27].

Good believes that only a semantic network can investigate the meaning of the categories of the disease – research should therefore focus on the words, emotions and all aspects of social interaction used to express forms of experience related to the illness. Networks of meaning that connect the experience of illness to the cultural values of a specific social context appear structured around a symbolic element; "heartache" in Iran is the central symbol around which narratives are constructed about several incidents to illness in women, such as childbirth, pregnancy, abortion, contamination, menstruation, oral contraception, and sterility. The concept of a semantic network takes into account the emotional and experiential elements that give meaning to a particular episode of illness and condenses the set of personal, social and cultural meanings that aggregate around suffering.
The second school of thought, developed from the critical review of the concepts of disease, illness, and sickness, adopts a perspective of analysis that aims to track, within the categories and the cul-

tural meanings of the disease, frameworks and structures of domain and power. The vast array of political, social, and economic powers that come into play in a given context, become the object of anthropological research, therefore outlining the shift from a "culturalist" approach to illness, focused on doctor-patient relationship, to a social-political approach towards the understanding of disease and sickness. G. Pizza summarizes this approach as follows:

> *Every therapeutic act is always a confrontation of powers, which is played in a more complex field of socio-political power relations. The doctor-patient relationship is always stuck in a field of relationships that is wider and broader. Just think, for example, of how that relationship is in fact crossed by external logic to the dyadic relationship, reflecting the dialectic hegemonic socio-political space – in relation to health policies and institutional activities of the State and in relation to families and others social subjects, depending on the situations and contexts*[28].

This theoretical approach, in direct opposition to that of Harvard, has created a thriving literary production; for reasons of relevance to the issues treated by the author of this study, I will simply mention the anthropological production that, even within the same theoretical current, has taken on the concept of "social suffering" as a specific subject of research. This is a concept that aims to investigate the relationship between the historical and social processes and experiences of discomfort, revealing how disease represents one of the ways in which social suffering arises.

> *Social suffering [...] includes a common set of human problems whose origin and whose consequences sink their roots into the devastating fractures that social forces can exert on human experience. Social suffering is the result of what the political, economic and institutional powers do to people, and, reciprocally, how these forms of power may themselves influence responses to social problems. Included in the category of social suffering, there are conditions that generally refer to different fields, conditions that simultaneously involve issues of health, welfare, but also legal, moral and religious aspects*[29].

This perspective focuses on the relationship between the subject and the social order, and the ways in which some forms of power may be involved in producing discomfort. Human suffering is a social fact, which deserves to be investigated as a result of the actions of the political, economic and institutional power. In this sense, the task of anthropology of social suffering is to understand the pathogenic role of this authority, which is equivalent to the assumption of a political commitment to promote social equity and, where necessary, to denounce human rights violations. It is not limited, in fact, to the analysis of cultural representations, and appears to be highly critical of those forms of relativism that tend to conceal social inequality.
One of the most significant contributions on these themes is that of Paul Farmer, a proponent of a theoretical view that suggests considering, as an object of anthropological study, the embodiment of historical, social and political processes in individual biographies, through in-depth historical and geographical. Considering the case of AIDS and tuberculosis in Haiti, he highlights how social forces of various kinds can produce what he calls "structural violence". This expression refers to Farmer "iatrogenic effects produced by a social order characterized by deep inequalities"[30]; a particular type of violence that is exerted in an indirect way, since it does not require a person to be performed, but rather it is produced within the same social order and by the inequalities that are produced within its interior.

> *The term is particularly appropriate since this suffering is "structured" by forces and processes created through history (often economically driven) that conspire - through routine, ritual or, as more often happens, the harshness of life - limiting the ability to take action*[31].

This is "structured and structuring", because not only is it inherent in the social makeup, but it also limits the capacity for action of those who occupy more marginal positions within contexts marked by deep social inequalities. In Haiti, AIDS and tuberculosis, and with

them racial, political violence and gender inequality, are considered various ways in which social suffering materializes in people's lives, as individual embodiment of wider social, historical and political processes. Farmer raises the question as follows: "Through what social forces, ranging from poverty to racism, are to be embodied as individual experience?"[32]; we need to understand how to hold together the individual experience of suffering with social forces and processes of large-scale in which cultural forms and social forces are involved. For the analysis of "structural violence", Farmer suggests considering three fundamental "axes of suffering":

> *Social factors including gender, ethnicity ("race"), and socioeconomic status may each play a role in rendering individuals and groups vulnerable to extreme human suffering. But in most settings these factors by themselves have limited explanatory power. Rather, simultaneous consideration of various social "axes" is imperative in efforts to discern a political economy of brutality*[33].

"The axis of gender" helps us understand why two people with the same status may fall victim to violence different; being a woman, in fact, often means suffering a subordinate relationship that hits directly in the intimacy of domestic life. In Haiti, the majority of women who die of AIDS, in fact, lived in a state of deep poverty. "The axis of the race" or ethnicity offers the opportunity to reveal how the definition of the differences in racial and ethnic manages to conceal the problem of economic and social inequality. The concept of "race" and that of "ethnicity" are often used to deprive the fundamental rights specific social groups – their use as explanatory criteria of suffering hides social inequalities "biologizing" or "ethnicizing" them, covering the fact that they are consequences of an unequal distribution of resources.

The axis that sees the combination of structural violence and "cultural difference", in conclusion, must be considered in order to cri-

tique that anthropological view that has confused, through a narrow relativist approach, social inequality with cultural differences. Approaches based on a concept of culture as an "essence" that men seem to have, has today led to a "culturalization" of suffering. Issues related to the management of power and institutional structures were frequently raised as an issue of alleged cultural changes in local contexts, to the detriment of the analysis of the structural elements affecting real balance of power. These axes of oppression must be considered as a simultaneous act, since there are factors that, if considered individually, may be decisive.

Only the concomitant action of social forces with varying nature is able to frame and give structure to the daily risk of exposure to certain diseases. In most situations, gender in itself is not enough to create a risk for this type of aggression to the dignity of the person. Poor women, in fact, are the most defenceless against these attacks. This applies not only to domestic violence and rape, but also to AIDS and its distribution[34].

These are issues that call into question the statistical and epidemiological parameters that currently govern health policies and humanitarian intervention, in areas where the suffering is related to a condition of structural violence, inherently positioned in the global economic and policies from which they are derived.

The complex traits of suffering can only be grasped through the personal stories and biographies. What the victims, past and present, share are neither, in fact, attributes of a personal or psychological character, nor can the common experience of suffering be generally attributed to culture, language or race. What the victims share is rather the experience of occupying the lowest point on the social ladder in inegalitarian society. Therefore, ethnographic work must come from biographies, which are located within the historical and social systems in which they develop. Farmer shows that the same mechanisms that create inequalities to restrict the ability of individual action in life choices, so they are crucial for understanding what

he calls "pathologies of power"[35]. Ethnography in disease experience is aimed at showing how the relationship between history, power and processes of embodiment are inscribed directly into the body, which becomes not only a place of organ dysfunction, but a reflection of a social order characterized and defined by deep inequalities.
Within this theoretical perspective, there are many works that welcome the concept of Foucauldian bio-politics[36]. Dissertations of the French philosopher around this concept have, in fact, been widely reported, and were accepted within the anthropological debate by virtue of their ability to question the relationship between power and biological life. According to Foucault, since the eighteenth century, we have been witnessing a radical transformation of the relationship of power with life and death. Up to the age of the Enlightenment, in fact, the sovereign power was the holder of the right to take life or let live, a right not absolute but relative to the defence and survival of the sovereign state. Sovereign power is exercised, therefore, as withdrawal, such as the right to take life. The eighteenth century, however, led to a major transformation: political power takes on the task of "managing life"; it transforms human life and enters the field of explicit calculations, for whom death is no longer the instrument with the most important domain, but rather the limit to continuously remove.

> *One might say that the ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death. This is perhaps what explains that disqualification of death, which marks the recent wane of the rituals that accompanied it. That death is so carefully evaded is linked less to a new anxiety that makes death unbearable for our societies than to the fact that the procedures of power have not ceased to turn away from death. In the passage from this world to the other, death was the manner in which a terrestrial sovereignty was relieved by another, singularly more powerful sovereignty; the pageantry that surrounded it was in the category of political ceremony. Now it is over life, throughout its unfolding, that power establishes its dominion; death is power's limit, the moment that escapes it; death becomes the most secret aspect of existence, the most "private"*[37].

What Foucault calls bio-power does not eliminate sovereignty, but rather penetrates and carries out life management through specific techniques. Between the seventeenth and nineteenth centuries, bio-power is developed in two main forms: the first has the body as its objective, the reinforcement of attitudes, the growth of its value in relation to the needs of the structures in which it stands. It is a discipline that Foucault calls "political anatomy of the human body"[38]. The second is the "Bio-politics of the population" and takes place in a series of regulatory controls related to demographic phenomena, birth and mortality, levels of health or lifespan; a term which refers to the way in which we have tried to rationalize the problems posed to governmental practice by specific phenomena of its population. These two forms of power over life in the eighteenth century still appear separate, but are an articulation in the nineteenth century, when for the first time the biological reality begins to be reflected in this policy, and the fact of life is no longer the inaccessible base that emerges only sporadically in the events of the death and fatality. It passes, at least in part, into the field of knowledge control and intervention of power.

In relation to this process of articulation, Foucault highlights the important role of the state, defined as a form of power that is also a power of collectivizing and individualizing. In the modern state, the body and bio-politics of the population tend to be articulated in particular ways. This can be achieved because it is able to integrate into a new political form and that of a power technique: that which is pastoral. Already present in Eastern societies, and introduced to Europe by Christianity, this power has certain characteristics. It rules over a multitude of people and not a territory; it guides the individual during the course of his or her life to ensure his safety; unlike the royal power the person must be able to sacrifice for their flocks; it is a form of power that can be exercised only by knowing the feelings of men, urging them to reveal their deepest secrets. Pastoral power

is not limited to compel the individual to perform certain tasks, but seeks to determine the relationship they have with themselves. The modern state must be considered a new form of pastoral power; it is an attempt to meld the political power exercised on the "legal entities" with the pastoral power exercised on living individuals. The art of governing therefore moves from the scope of the Christian pastoral power to that of civil society; it no longer guarantees the salvation in the hereafter but rather guarantees it in this world: health, hygiene, birth rates, longevity, well-being, and security are taken over by this new power. Bio-power has been one of the elements essential to the development of capitalism, which could not have been achieved without the inclusion of bodies in the apparatus of production and without an adaptation of the phenomena of population to these economic processes.

This new pastoral power is exercised by public institutions, the family, and complex structures, such as medicine. The first pole in which bio-power is made up of the disciplinary techniques, which allow for the detailed management of the population through direct intervention on individuals and aims to make them "docile". The other pole is that of bio-politics of the population, which indicates the ways in which they have tried, since the eighteenth century, to rationalize the problems posed by the population to governmental practice. The procedures for standardization to regulate subjects invade more and more the scope of the law. The norm applies, in fact, to the body of individuals with regard to the population, creating a "society of normalization". This expression means not a generalized disciplinary society, but rather a society in which norms of discipline and the norm of regulation both interact. An emblematic case is found in medicine, which since the nineteenth century has acted a great deal on bodies as well as on the population. In *Birth of the Clinic*, Foucault highlights the establishment of a process of "medicalization" of society, through which the doctor's view enters social space

in order not only to cure diseases, but also to identify and provide specified health parameters. In this manner, the clinic assumes a role of legislation and norms.
Bio-power affects bodies and the population, also acting in areas outside of disease – this is even more evident if we look at sexuality.

> *With this background, we can understand the importance of sex as a subject of political struggle [...] On one hand, sex participates in the disciplines of the body [...] while on the other it participates in the regulation of all peoples through the global effects that it induces. It fits simultaneously on two registers; it gives rise to infinitesimal surveillance, constant control, as well as organization of the space of an extreme meticulousness, a medical or interminable psychological examination, and an entire micro-power over the body; but also gives rise to massive measures, to statistical estimates, with interventions that target the entire body or social groups as a whole*[39].

Sexuality allows bio-power to reach and affect life, providing access to the life of the body and that of the species. Sexuality is related to power strategies, and it is the set of the effects produced in bodies, behaviours and social relations from a specific device that is dependent on complex political technology. Sexuality is so disciplined, pursued in our existence, and at the same time becomes the theme of political operations, economic interventions (such as incitement or brakes on procreation) and ideological campaigns of moralization or empowerment.
If Foucault, through the concept of bio-power, clarifies the relationship between politics and health, identifying a particular historical break that occurred in the West in the age of Enlightenment, Didier Fassin, while accepting to address the concept of bio-politics, develops a thesis that exceeds that specification and considers the geographical and temporal power in local forms in which it works.
In his famous work *L'Espace Politique de la Santé*[40], he provides us with a new definition of health, which takes on a double meaning:

> *Health therefore appears simultaneously as a concept and as a space defined by the relationship between the physical and the social body. [...] A notion where we find meanings developed both by common sense and by the learned knowledge. This is a space that connects an ensemble of agents that meet there as patients, professionals and administrators*[41].

Health insofar as a "notion" comes forth as a cultural creation, in which common sense and official knowledge interact – health as a political construction, on the other hand, describes a space in which the action unfolds in a multiplicity of social protagonists who vie for the meaning and definition of the aforesaid "notion". Conceiving health as a political space offers the opportunity to reveal those power relations inherent to the processes of health and disease, freeing them from a description that conceives them as natural and objective reality. Therefore, we can investigate the links between "official knowledge", represented by the powers of the state, and "common sense". It is at this point that a space opens up for interaction with the analysis of processes of embodiment, which aims to highlight the link between physical well-being and social, historical, and political forces. Much like Farmer, the French anthropologist sees disease not as an objective reality inscribed in the body, but rather as a social reality from which power relations emerge. Social order is mirrored, in fact, in the body, which can become an expression of the unequal distribution of resources of care and, consequently, the different possibilities of surviving the disease or not. The analysis of the relationship between physical well-being and state policies shows that health may be included as the possibility of access to tangible and intangible resources that ensure high levels of life satisfaction; the disease can be, on the contrary, the impossibility of access to these resources, and therefore a form of embodiment of inequality. According to this perspective, health is set up as a social and political problem, and the difficulty of access to resources and services that protect people become an expression of social injustice that characterize a given context. Social

inequality produces disparities, and differences in status or wealth can be inscribed to bodies, turning social aspects into biological issues. Within the political world of health and health care, a set of powers takes action. The powers are involved in the political management of bodies: "public health", understood as collective health management governed by the state, to raise the issue of the possibility of access to resources that guarantee wellness. It is therefore a place of interaction of a set of powers that play a central role in the definition of the concept of health and ensuring, or not, access to resources that ensure the well-being. The state plays in this respect, a key role. The state is responsible for the collective management of disease:

> *The role of the state and therefore central: as the monopoly of legitimate violence and founder of social protection systems, in terms of the embodiment of inequality; as the supreme example of legitimization of actors and arbitration of conflicts regarding the power to heal; as defender of the public good and guarantor of public order, with regard to governing lives*[42].

Violence informs the aforesaid state policies and through them these bodies are inscribed. An exemplary case is found in French policies on immigrants without residence permits; regulatory policies adopted by European states for access to territories of illegal aliens has been delayed by issues regarding the right of asylum as well as the right for care – following amendments to legislation, all possibilities of obtaining a residence permit have been limited, while health and disease have become progressively more useful for obtaining legal status. If citizenship is the basis in order to claim certain rights, illegal immigrants cannot be considered *holders of such rights*; only in cases where there is a clear threat to the biological existence of immigrants will the immigrant be granted the right to enter or remain in France without papers.

> *The legitimacy of the suffering body, offered in the name of a common humanity is opposed to the illegitimacy of the racialized body, promulgated in the name of an insurmountable difference. [...] The body has become the*

site of inscription for politics of immigration, defining what we can call, using Foucauldian terminology, a bio-politics of otherness[43].

"Bio-politics of Otherness" must be understood as the extreme reduction of social to biological systems. The suffering body has imposed its legitimacy whereby there were no other bases that would guarantee legal status; this became the place of last political legitimacy: only as that "bare life" illegal aliens receive as recognition. Violence lies not only in the countries from which they are forced to flee, but also in the hospitality and immigration policies and practices of the host countries.

BIBLIOGRAPHY AND NOTES

1. The Cartesian dichotomy, however, was rethought by the same Descartes, who wrote in his famous *Passions of the Soul*, while recognizing the primacy of the mind over the body, he affirms that such a distinction exists in terms of methodology but not experiential.
2. PIZZA G., *Antropologia Medica. Saperi, pratiche e politiche del corpo*. Roma, Carocci, 2005, p. 56.
3. MAUSS M., *Techniques of the Body*. In: MAUSS M., *Outline of a general theory and other essays*. Torino, Einaudi, 1965, p. 385.
4. Ibidem.
5. PIZZA G., *Antropologia Medica. Saperi, pratiche e politiche del corpo*. Roma, Carocci, 2005, p. 31.
6. Ibidem, p. 40.
7. CSORDAS T. J., *Embodiment as a Paradigm for Anthropology*. Ethos. Journal of the Society for Psychological Anthropology 1990; 18(1): 5-47.
8. Both have developed the notion of embodiment, the first from a phenomenological approach of perception (MERLEAU-PONTY M., *Fenomenologia della percezione*. Milano, Il Saggiatore, 2003); the second, from theory to practice, develop the notion of body technique by Mauss: the *habitus* is "A system consisting of socially structured and structuring provisions, acquired with practice and oriented towards practical functions" (BOURDIEU P., *Per una teoria della pratica. Con tre studi di etnologia cabila*. Milano, Raffaello

Cortina, 2003, p. 206). The provisions embodies by the individual are structured - as a result of social forces acting in a social field - and structuring - as producers of new representations and new social practices. (BOURDIEU P., *Per una teoria della pratica. Con tre studi di etnologia cabila*. Milano, Raffaello Cortina, 2003).

9. CSORDAS T. J., *Embodiment as a Paradigm for Anthropology*. Ethos: Journal of the Society for Psychological Anthropology 1990; 18(1): 5.
10. PIZZA G., *Antropologia Medica. Saperi, pratiche e politiche del corpo*. Roma, Carocci, 2005, p. 42.
11. Concept already introduced by M. Mauss, 1965 in reference to the set of culturally-informed uses of the body in society.
12. CSORDAS T. J., *Embodiment as a Paradigm for Anthropology*. Ethos: Journal of the Society for Psychological Anthropology 1990; 18(1): 41.
13. SCHEPER-HUGHES N., LOCK M., *The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology*. Medical Anthropology Quarterly 1987; 1: 6-41.
14. SHEPER-HUGHES N., BOURGEOIS P., *Violence in war and peace. An anthology*. Malden, Blackwell Publishing, 2004, p. 31.
15. GOOD B. J., *Narrare la malattia. Lo sguardo antropologico sul rapporto medico-paziente*. Torino, Piccola Biblioteca Einaudi, 2006, p. 14.
16. AUGÉ M., HERLICH C., *Le sens du mal. Anthropologie, histoire, sociologie de la maladie*. Paris, Des archives contemporaines, 1983, p. 34.
17. Ibidem.
18. Ibidem.
19. SINDZINGRE N., *La necessità del senso: la spiegazione della sventura presso i Senufo*. In: AUGÉ M., HERZLICH C., *Il senso del male. Antropologia, storia e sociologia della malattia*. Milano, Il Saggiatore, 1987, p. 89.
20. PANDOLFI M., *Dall'antropologia medica all'antropologia della malattia*. Antropologia Medica1986; 1: 45.
21. PIZZA G., *Antropologia Medica. Saperi, pratiche e politiche del corpo*. Roma, Carocci, 2005, p. 89.
22. ZEMPLENI A., *La maladie et ses causes*. Paris, L'ethnographie, 1985.
23. FRANKENBERG R., *Medical Anthropology and Development: A Theoretical Perspective*. Social Science and Medicine 1980; 14B: 197-207. 24
24. YOUNG A., *The Anthropology of Illness and Sickness*. Annual Review on Anthropology 1982; 11: 257-85.
25. PIZZA G., *Antropologia Medica. Saperi, pratiche e politiche del corpo*. Roma, Carocci, 2005, p. 89.

26. KLEINMAN AM., *Explanatory models in health care relationships*.Washington, D.C., NCIH, 1975, pp. 159-172.
27. GOOD B. J., *Narrare la malattia. Lo sguardo antropologico sul rapporto medico-paziente*. Torino, Piccola Biblioteca Einaudi, 2006, p. 33.
28. PIZZA G., *Antropologia Medica. Saperi, pratiche e politiche del corpo*. Roma, Carocci, 2005, p. 89.
29. KLEINMAN A., DAS V., LOCK M. (eds.) , *Social Suffering*. London, Berkeley, University of California Press, 1997.
30. FARMER P., *An Anthropology of Structural Violence*. Current Anthropology 2004: 45(3): 305-325.
31. Ibidem, p. 280.
32. FARMER P., *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. London, Berkeley, University of California Press, 2003, p. 30.
33. FARMER P., *An Anthropology of Structural Violence*. Current Anthropology 2004; 45(3): 305-325.
34. Ibidem, p. 286.
35. FARMER P., *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. London, Berkeley, University of California Press, 2003.
36. AGAMBEN G., *Homo sacer. Il potere sovrano e la nuda vita*. Torino, Einaudi, 1995.
37. FOUCAULT M., *Gli anormali. Corso al Collège de France (1974- 1975)*. Milano, Feltrinelli, 1999, p. 122.
38. Ibidem, p. 123.
39. FOUCAULT M., *Gli anormali. Corso al Collège de France (1974- 1975)*. Milano, Feltrinelli, 1999, p. 12.
40. FASSIN D., *L'éspace politique de la santé*. Paris, Presses Universitaires de France, 1996.
41. Ibidem, p. 35.
42. Ibidem, p. 47.
43. FASSIN D., *Entre la politicas de lo vivente y las politicas de la vida. Hacia una antropología de la salud*. Revista Colombiana de Antropología 2004; 40: 283-318.

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