Of Malady and Misery. An Africanist Perspective of Illness in Europe

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Of Malady and Misery
An Africanist Perspective of Illness in Europe

Sylvie Fainzang

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Preface

If we replace the word “philosophy” by “anthropology” in a sentence from Canguilhem, we could say that anthropology too “is a reflection for which all unknown material is good and, we would gladly say, for which all good material must be unknown” (Canguilhem 1984, p.7). It is not that anthropology is “the science of problems that have been solved”, as Léon Brunschvicg described philosophy (cited in Canguilhem 1984, p. 9), but rather that it is the science of unknown objects. Even if the anthropologist is dealing with subjects with which he is in fact familiar, he must always treat them as if they were “foreign” to him.

This is the rule, which the investigator working at home, in Western societies, must observe. The fact that he is dealing with matters, which may appear to him self-evident, makes it even more important to stick to the rule. We too easily treat phenomena belonging to our own culture as “natural” when in fact they are not the product of “nature” at all but simply of society and culture.

The notion of “home” is by no means as simple as it may at first appear. It gives rise to a number of questions, as far as when we conduct our research “at home”, we find ourselves faced with new problems. It was this fact taht led to academic reflection at a European Conference on “Medical Anthropology at Home”, organized by the University of Amsterdam and held in Zeist, in the Netherlands, in 1998. Besides, the expression “at home” is both polyvalent and relative.

It is polyvalent because its meaning varies with the context. It may indicate a country (France, for example), or a continent (Europe), Western societies taken collectively, or a specific culture. Even if “working at home” is used with the single meaning of working on familiar and not on a strange field, it may still be applied to a variety of social realities and activities to which the subject feels that he in some way belongs: an institution, a physical or professional activity, even an illness. Any attempt to give a comprehensive explanation of the term “at home” must recognize that it always involves at least two situations and therefore implies some degree of sharing with informants, whether of an experience or of culture.

Secondly, being “at home” is a relative notion. Any European may feel at home in the West or in Europe, but this does not mean that a Dane feels completely at home in Italy. It is a question of cultural boundaries. Within a same society too, there are differences, cultural and religious, as well as geographical, so that a thing can be both familiar and strange. The same principle of boundaries applies to the groups studied by the anthropologist. When he is studying a migrant group in his own country for instance, is he

doing anthropology “at home”, or is he practising “exotic anthropology”? It is clear that the notion of anthropology “at home” is a changing and fluid notion.

By “at home” in the present study I mean “belonging to French society”. No doubt, French culture, like every contemporary culture, is a complex reality characterized by a growing cultural plurality. It is then necessary to study all the groups and not only the ethnic minorities. In the same way, we must study individuals involved in the medical service as well as those who are impregnated with beliefs considered unknown to scientific rationality.

Anthropological research traditions teach us to connect relevant data concerning the domain studied (health and sickness) to other domains and other levels of social life. I subscribe to the idea that social anthropology is a unified whole: that is to say; *there is only one anthropology* which, although it studies distinct empirical objects, yet is not fragmented. My position here is similar to that of Augé (1986), and to that of the anthropologists of the *Ecole des Hautes Etudes en Sciences Sociales* in Paris. Therefore, I believe that the practice of medical anthropology, whether in Western or in other societies, should not be separated from the other fields of anthropology.

This remark, epistemological in nature, is intended to emphasize that the specific focus of medical anthropology on the medical field does not make it any less imperative to study the links between this object and other domains, even if the fact of practising in one's own society makes this difficult. This is the specificity of research "at home." For the anthropologist working "abroad," it seems obvious that a given therapeutic practice must be linked to the political and religious domains, to kinship or to social organization. But for the anthropologist "at home," this same step (which makes medical anthropology a simple bridge towards a better understanding of the individual in society) seems much more complex, the phenomena and data associated with illness being perceived – perhaps wrongly – as operating with greater autonomy.

Medical anthropology then conducted “at home” brings its own special difficulties, due in part to the lack of distance between the observer and his subjects (on the constraints and the special difficulties involved in practising anthropology in a European society, see also Fainzang 1998). This distance must however be constructed if the analysis is to be effectively carried out. It is possible, as it is also essential, to look at the familiar with the eye of the outsider. By rendering the familiar foreign, and looking at French society with the same astonishment with which the European usually looks at an African society, we become able to discover the symbolic mechanisms underlying behaviour which we are initially tempted to regard as evident and natural.

The study which follows shows how the anthropologist with African experience is able to unmask the apparent “naturalness” of behaviour which

members of French society take for granted. As the exercise of examining Western culture obliges the observer to pay attention to what may seem to be the most obvious elements in our thinking and acting, this perspective makes it possible to perceive the social and cultural character of our categories of thought and behaviour. Thus we are led to re-examine and re-think what makes our society like, or unlike, other societies.

The present work is the fruit of research carried out nearly fifteen years ago and published by the Ecole des Hautes Etudes en Sciences Sociales in Paris (Fainzang 1989). In this study, after relocating my earlier Africanist work in the context of research in the anthropology of illness, I explain how I came to change field. I speak of the tools I have used and of the modifications in method and the different problems which the change of field involved. I then present the framework of my investigations, the essential elements of the ethnographical study, the different hypotheses I used to guide my reflection, and my results. Finally I adopt a comparative perspective and seek to cast an “Africanist” eye on my materials. By placing alongside each other my findings in Africa and France, I try to draw out significant features which will make it possible to determine if there are certain constant elements in the processes I have observed and thus to construct general models applicable to all societies. I believe that this approach will help to bring out, through the different representations of illness and the symbolic systems which underlie them, the essential sameness of the human being as a social being.

At the conclusion of this study the reader will find a "postcript" (aftermath) which describes the orientations taken by medical anthropology during the last decade and shows how my own subsequent work is inspired by the wish both to enrich social anthropology in Western society and to contribute towards a better understanding of human societies in general.

I wish to conclude by offering my sincere thanks to Marc Augé for the valuable comments and suggestions which inspired me to undertake this work. I am also grateful to Els van Dongen and Sjaak van der Geest for their great interest and which made it possible to produce this English version.

I. A REVIEW OF THE PAST

Medical anthropology starts from the assumption that illness has another dimension apart from the narrowly biological and that each culture has its own specific representations of illness and its own way of treating it. Researches in the English-speaking world have shown the close connections between illness and the social organization and thought-systems of particular societies. The conclusion of these studies has been that what is called illness cannot be defined simply in the terms of bio-medicine. The works of Rivers (1924), Clements (1932) and Ackerknecht (1946, 1971) in particular have been of great importance in promoting an anthropological reflection on illness, distinct from the analyses of bio-medicine. The principal effort of W.H.R. Rivers was to try and discern the concepts of illness elaborated by different societies (1924, 6). He was the first to make a systematic connection between traditional medicine and other aspects of the culture and organization of the society concerned, and he showed that medical practice is a social process (ib. p. 55) and must be studied in the same way as other social processes. Medical concepts which we may consider mistaken are nevertheless still based on a logically coherent body of beliefs (p. 51).

Ackerknecht (1946) was interested in the relation between "primitive culture" and "primitive medicine", and, following the lead of Hallowell (1941), showed that the representations and practices concerning illness operated as instruments of social control. The work of Turner (1968) supported this thesis.

The principle thus came to be accepted that medicine is an art of social usages, and on this basis many anthropologists, mostly English-speaking, set about investigating how different societies use their representations and practices in the field of illness to exercise control over individuals. The outcome of this research has been to show how illness, as an experience of misfortune affecting both the individual and the group, gives rise to practices which go well beyond anything that may be regarded as belonging to the strictly medical field (cf. Turner 1968, Evans-Pritchard 1968).

The work of Evans-Pritchard on the concepts of witchcraft among the Azande falls within the general theoretical scheme elaborated by Rivers in that it offers an analysis of the thought-processes involved in the experience of illness and healing. Evans-Pritchard's special contribution however was to show how apparently irrational beliefs concerning the origin of misfortune, and the appropriate methods of dealing with it, make sense when they are situated within the total social context.

Alongside this "functional" approach to anthropological medicine there also developed what Wellin (1977) called a "cognitive" approach which focuses on

the patterns of thought into which medical knowledge in traditional societies is fitted.

The principle that facts relating to illness cannot be studied in isolation from other social facts, like family, religion, and conceptual system, is the guiding principle of the anthropological study of illness. Since Evans-Pritchard in particular, the observed phenomena of medical interpretation and treatment are considered as aspects of the general anthropological data from the society concerned.

Marc Augé used data from the Ivory Coast to show that, in the spirit of Evans-Pritchard, not only are ideas and practices relating to illness inseparable from the wider symbolic system, but also, that they are connected with the general theories which structure the symbols of people's thinking (1975).

This theoretical position led Augé to reject the notion of "medical anthropology" as a separate discipline with its own definition. In his view, there is a single subject, anthropology. It has "empirically distinct objects", but these constitute a single field of study (1986: 81). He prefers therefore to speak of an "anthropology of illness ", implying by this expression that illness is for the observer only one object among many. It is "a concrete example of the intellectual connection between individual perception and social symbolism", and it should enable the anthropologist to penetrate more deeply and with sharper insight into the general anthropological problem (ib. 82).

It may be noted finally that the development of this field of research has led to collaboration between anthropology and connected disciplines, notably psychology and psychoanalysis. So the work of A. Zempléni has brought out the persecution complex which underlies the systems of illness-interpretation in African societies.

In common with many anthropologists, I have found that the study of how people in a particular society see and deal with illness provides a privileged and sometimes even indispensable means for understanding that society. My own research in West Africa among the Bisa of Burkina Faso[1] helped me to perceive the role which conceptions of illness play in structuring a variety of social practices: economic, religious, matrimonial. These conceptions are connected too with local representations of the universe and with the social organization of the Bisa. All this led me to study the logic which lay behind therapeutic strategies.

This research in fact took place at the confluence of the two general orientations described above. It was partly inspired by the work of English-speaking theorists on the social function of illness, for I was interested

[1] A population of agriculturalists. Traditionally they practise the cult of ancestors and of a variety of spirits, especially the spirit of the earth, but part of the population has been converted either to Christianity or Islam.

in the ways in which society used the theory and practice of medicine to ensure its own reproduction. At the same time I tried to understand the meaning which illness had for the Bisa and to see how it fitted into their general patterns of thought. Special attention was therefore given to explanatory models of the event of illness and in particular to the accusatory processes which it generated and which were closely connected with the therapeutic treatment. A major focus of this research was the meaning given to illness and its pretended causes. This involved examining the systems of causality developed by the groups concerned and the explanations of illness produced both by individuals and by the relevant traditional institutions. Among the Bisa, the systems of illness-interpretation are manifested especially in the work of healers and diviners. These constitute two separate professional bodies, the first being concerned uniquely with *manifestations* in the form of bodily symptoms, and with their cure, and the second with illness as an *event* demanding explanation.

People consult the diviner because they perceive illness as a social event, and the diviner seeks to make a connection between the behaviour of his clients and past events. His task is to uncover a causal pattern underlying a wide variety of phenomena. The study of divination helped me to perceive the principles governing the consultation and to appreciate its great flexibility. It is this flexibility which gives the diviner his power. Before making his diagnosis and prescribing the appropriate rituals, he assembles as much information as possible. It is accepted that his prescriptions may cover a wide range of social practices, for these are regarded as the conditions of the cure or as means of preventing illness.

In this arrangement, illness is treated as just one event among others. People consult the diviner for all kinds of purposes so that he has a variety of roles. Within the wider world-view of the Bisa, illness is regarded as a significant event connected in a causal chain with other events in the life of the individual and the group. It is usually regarded as a punishment inflicted by supernatural powers for the breach of a taboo, and it may be the result of action by *Woso*, the transcendent principle of the universe over which human beings have no control. (On this point, research has tended to bring out the distinctive content of symbolic categories like those of the spirits and of *Woso*, for the meanings and uses of these notions are sociologically antagonistic. In this connection, I have shown that the word *Woso*, usually translated "God", does not in fact belong to the strictly religious category.) Illness can also be the result of persecution on the part of a third party, and it is then the expression of conflict between individuals or groups. At the same time illness has a special role as a threat, and it can underlie consultations which do not take it as their immediate object. Thinking about illness takes one into the temporal and logical field of a whole chain of events. The way people see illness tends to

legitimise specific social behaviour situated at different points along the chain and liable to alter its course.

The connection between the event and social practices comes within the purview of the divining institution because of the specific relationship which diviners are supposed to have with the world of knowledge. They are thought to be able to penetrate to the inner reality of things.

In the light of all this, I thought it useful to push further the functional analysis of divination as social control, although I am not in agreement with all the conclusions of functionalist anthropologists. I showed that divination in fact aims at comprehensive social reproduction, for the theoretical treatment of illness is concerned not only with social norms and law: the diviner is authorized to intervene in all areas of social life. The institution of divination bestows on the consultant authority to prescribe all kinds of things: distribution of goods, changing residence, choice of a marriage-partner, acceptance of a responsibility. The function of both his diagnosis and his prescriptions is to reinforce the social order and to secure its reproduction. His main concern is to ensure respect for the principles of the social, economic and juridical organization of society. To this end he identifies as the primary cause of an illness the failure to observe the rules in such matters as production, marriage or inheritance. He is also concerned with the traditional observance of the cult of ancestors and spirits, with the consolidation of social roles, and with the proper relations within the group. So he is interested in ensuring social cohesion on the occasion of a funeral, for example. The institution of divination manipulates events to ensure social reproduction.

It is not only illness or misfortune that is used in this way. Good fortune too is submitted to the same logic. In this respect, I see a parallel between divination and behaviourist theories. Both are concerned with ensuring the survival of a system, and both are based on the notions of punishment and reward, illustrated here by good or bad fortune. The difference is that behaviourists actually bestow punishments and rewards, while diviners only identify sanctions or rewards by interpreting events. The intellectual elucidation of the event generates social practices.

This analysis however does not mean that everything is structured and determined in such a perfectly balanced way that all change is excluded, as the functionalist school tends to suggest. On the contrary, when one considers how the category of *Woso* is used in social life, it is evident that some representations of illness are completely "dysfunctional". People have recourse to *Woso* explanations precisely to escape from divination, and in this way they express their resistance to social control. In opposition to the British functionalist school, I show how these same systems of interpretation enable sick people to manifest resistance to the social control represented by the system of diviner-diagnosis of illness. The general picture is that both social

conformity and resistance to such conformity can be validated by the way illness is interpreted: the system of accusing the sick person or a third party for the appearance or aggravation of illness is in competition with the theory of "Woso's illness", a formula which contradicts any comprehensive theory of human responsibility for misfortune (cf. Fainzang 1986).

II. HOMECOMING

Many anthropologists have been attracted by the idea that their discipline has a universal relevance, and they have begun to conduct research in Western societies also. They are particularly interested in such things as politics, how individuals take initiatives, and how tiny, usually marginalized, urban groupings function. Anthropology cannot in fact be reduced to the study of exotic societies. Speaking of the specific interest of anthropologists, Jean Comaroff remarked justly: "It is not the *locus* of their data, but the analytic *focus* which sets them off from other social scientists.... Their analytic focus is essentially holistic: social phenomena are to be comprehended within their broader socio-cultural context" (1978, 247).

I, too, was attracted to the idea that the anthropological perspective could be applied to our own societies, but I was also aware that the results of my research in Africa raised questions which arise in the West as well. In studying the phenomenon of illness in French society, I have therefore chosen to use the model of my West African research.

Illness raises questions of universal relevance concerning such things as the relation to the body, the religious feeling and the interaction between the individual and society, although the questions receive different answers in different societies.[2] It seems to me that in the West no less than in Africa, the interpretation of illness and the motives behind recourse to therapy go far beyond the strictly medical. They involve systems of thought and representations of reality which it is precisely the function of the anthropologist to study and decipher. It therefore seems to me that the anthropology of illness can and should be applied to Western societies, for the representations and practices of illness there are no more independent realities than they are in the lineage societies of Africa, for example. In the West too conceptions of health and illness are connected with systems of representation inherited by individuals and incorporated in their social activities.

It is to be observed furthermore that the global perspective proper to anthropology, and its specific interest in cultural facts, means that medical anthropology, acquainted with the problems of classical social anthropology, especially in the African context, has a perspective which cannot be identified with that of the sociologist. It offers a new and often complementary approach. The phenomena connected with illness have in fact provided material for a number of research projects in the social sciences. Such projects start from the idea that illness is to some extent a social construction. In France, sociologists,

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[2] It may be noted that as early as 1951 Talcott Parsons suggested using anthropological notions like ritual and magic in the study of different aspects of Western medical practice.

especially Herzlich, have shown that illness is by no means a uniquely medical phenomenon. Like the concepts of body and health, it expresses the relations between the individual and society, and is connected particularly with the categories of work and production and the notions of activity and inactivity.

The task which I have set myself is to provide an outsider's view to the anthropology of France. I would certainly insist that this research belongs to the general subject of works of French or European ethnology, but it has its own original character derived from the African experience by which it is inspired, or from the "detour", to borrow the expression of G. Balandier, this experience was.

The enterprise is not new. Other ethnologists too have unpacked their trunks, still warm from the African sun, and spread their contents over the land of France.

I am thinking especially of Gérard Althabe (1977) and of his pioneering work: pioneering both because it was carried out in an urban milieu and because of the way in which the author used as his material the relationships between the observers (himself and his team) and the residents of low-cost urban housing estates. Althabe however, while choosing a new field, also chose a new object for his research[3], whereas I have retained my former object.

My research began in fact as a kind of bet, with myself rather than with the community of "exotic" anthropologists, that the same approach, with certain nuances to be analyzed later, and the same problems, were no less relevant in the West than they had proved to be in Africa.

No doubt there are those who would consider this project something of a dream. They would maintain that all purely cultural and symbolic systems have been crushed under the steamroller of Western rational thinking, and they cannot imagine how it is possible to carry out an anthropological type of investigation into the representations of illness in a "modern" milieu.

The truth is however that the fruit of such an investigation is precisely to show how Western culture, French culture in this case, with the various minority cultures included within it, is to a large extent dominated by symbolic systems of thought, as Marshall Sahlins (1976) discovered in his semiological study in North American society.

It should be said finally that this "re-importation" to France is not to be regarded as in any sense a withdrawal. It is more a question of using an African experience to achieve a new openness to a radically different social reality. My aim is to continue my research while incorporating new hypotheses

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[3] Althabe is an Africanist whose speciality is political anthropology. In particular he has studied the political life of village communities on the east coast of Madagascar (1982). In France he has studied the social logics governing life in the great conurbations and the social changes resulting from town planning projects. On the basis of this material he elaborated an urban and industrial anthropology (Althabe, Légé and Selim, 1984).

derived from the milieu now being studied. I am putting the same questions as those which emerged from my enquiries among the Bisa, but now in a comparative perspective.

I shall return in more detail in the final section of this text to what I mean by "comparative". It may however be said at the outset that a comparative study of this kind is not intended to show the differences between the medical systems of the lineage societies of Africa and those of modern Western societies. Such a project would involve making a radical distinction between different levels of rationality, and this would be of no interest for anthropological reflection. My aim is rather to use the anthropological study of illness in the two kinds of society in order to uncover the universal elements underlying different symbolic systems, while also bringing out the specific differences between them.

III. THE CHOICE OF THE FIELD

The field which I chose for my research was the commune of La Ville-du-Bois, on the Ile-de-France. It contains five thousand inhabitants and is situated on the third ring of the Parisian region, to the south of Paris in the Department of Essonne. It has three principal characteristics which determined my choice.

In the first place, La Ville-du-Bois is situated in what is called the periphery of the city. These peripheral, still half-rural areas have been notably neglected in French ethnological research. There have been anthropological studies on urban areas, both in Paris and in the industrial cities (cf. Althabe, Légé & Selim 1984; Althabe, Marcadet, de La Pradelle & Sélim 1985; Pétonnet 1985), and also on rural areas (cf. Favret-Saada 1977; Verdier 1980; Zonabend 1980), but the outer urban areas, with their special characteristics, have attracted little attention.

When I use the term "urban periphery", I am not referring only to a community's geographical position as "around" an urban centre. This would turn it into a suburb, which is not the same thing. I use the term with the sociological meaning of a world which is marked by urbanization but still possesses also a non-urban character. One might also call it "semi-urban", in the sense that the district which we are here considering was until recently an agricultural, rural community. Some eighty of the inhabitants are in fact still involved in agriculture. The district is however in the process of urbanization and is becoming absorbed into the wider Parisian conurbation. One might also describe it as "post-urban" in that it is involved in the extension of the capital. It may certainly quite properly be called "peri-urban" since it is inside the area of intense urbanization and employment and functions as a receptacle of that urbanization and of the general spread of urban communities. It might however be more exact to describe it as "rurban" (cf. Bauer and Roux 1976).

The ethnologist looking for a peri-urban community such as I have described could hardly hope to find a better example than the commune of "La Ville-du-Bois", which may be translated "The Town in the Woods". It is a subtle mixture of the urban and the rural, and to call its inhabitants as "Urbisylvans" neatly summarizes its character as a complex hybrid, *urbs* and *silva* being happily combined for the purpose of this project.

In the second place, La Ville-du-Bois is both multicultural and multi-ethnic. There are the long-established families of market-gardeners and a more recent population of both working and professional people, coming in part from a city milieu. There are also Gypsies and Yenishes, the latter a people of Germanic origin whose traditional nomadic way of life resembled that of the Gypsies. In addition, there are Portuguese, Poles and Bretons.

La Ville-du-Bois is thus a complex and heterogeneous community in which

different systems of thought and diverse cultural practices confront each other. The co-existence of all these elements in a single community makes it a precious field of research for the professional study of different illness-representations and practices.

I should point out that I was not seeking necessarily to work in a community with an African population, because I did not wish to be dealing with material which could only be explained in terms of models imported from Africa. As I shall indicate later when I come to speak of my hypotheses, what I wanted to show was that the logic of different therapeutic conceptions and practices is not the exclusive product of any particular cultural system. I was not thinking of any so-called "African system of thought", but seeking rather forms of thought and conduct which can be found in very different kinds of communities and which reveal a general form of thought and conduct proper to human beings in society.

As one might expect, the socio-cultural pluralism of La Ville-du-Bois is reflected in a similar medical pluralism. This does not mean that every kind of medical culture is actually represented in the commune; but the people living there may still go outside its boundaries to seek therapies not available at home.

There is a Medical Centre in La Ville-du-Bois in which three general practitioners work, on a private basis, in a building rented from the municipality. There are also two nurses and a physiotherapist. A Counselling Centre, open one day a week, has also been recently established on the initiative of local psychiatrists from a neighbouring commune. There are no medical specialists in La Ville-du-Bois, and the inhabitants are obliged to make frequent trips to Longjumeau if they wish to visit a hospital, clinic or maternity facility.

Some of the inhabitants frequent “magnetizers”, of whom two practise in the commune while two others reserve their "gift" for the members of their own families. Some people too, especially Portuguese, have recourse to female clairvoyants under the guise of "medical consultations", and some visit traditional healers.

This wide medical spectrum seemed to offer an exceptionally promising field for the study of many different approaches to therapy, and so for identifying the general logic underlying them all.

IV. THE PROBLEM IN GENERAL

I have then used my study of this particular community to bring out general questions concerning models of interpretation of illness, and to identify the different logics governing attitudes to health and therapeutic practices. My ultimate goal was to produce an analysis of the interpretation of illness which would be of universal validity.

This project is in continuity with my previous work in the sense that it seeks to understand the meaning, not only of what people say about illness, but also of therapeutic procedures, in terms of the social relationships between individuals themselves, between the individual and the group, between the group and the world.

The first task must be to determine the primary explanatory models governing the approach to the experience of illness. I start from the hypothesis that interpretations of illness and of therapeutic procedures cannot be considered in isolation from the wider social life and from symbolic systems in general. On this basis I seek to bring out the connection between representations of illness and other symbolic systems, to determine the coherence between representation and practices, and to see how these fit into the cultural specificity of different groups. The broad perspective of the project means that the data have to be located within the general context of the particular culture, and the observed phenomena analyzed according to the meaning which they have for the interested parties.

In the same way, I consider from the point of view of the underlying symbolic systems both the different types of observed therapeutic procedures, whether these are defined as official, parallel or traditional medicine, and the relations between patients and healers.

While observing the kind of therapy to which people have recourse, I study also the "extra-medical" behaviour of sick people and their entourage. This involves considering to some extent the circumstances surrounding the illness - biological, social, economic, cultural, familial - and integrating these into the study of the existing social and family relationships. More importantly however we have to study the emergence of the illness-event itself, since this can be the beginning of new social and family relationships. I was especially interested in the modifications which illness creates in the relationships between the individuals concerned, whether these are specific consequences of the illness itself, like handicaps or withdrawal from work, or connected with the treatment: staying in bed, hospitalization, sojourn more or less long outside the family milieu, special diet.

As these reflections make manifest, the study of the place of illness in daily life must involve considering its impact on the family. Classical anthropology

has in fact always been interested in the connection between family systems and illness. It is these systems which interpret illness and even determine its incidence, and they also determine who is to be responsible for the consequent nursing obligations. It should be noted however that I use the word "family" to denote the wider kinship network and not simply the nuclear group of parents and children, although this is the prevailing model in Western housing arrangements. Family relations are wider than those between members who share the same residence.[4]

My study aims finally to bring out the role of cultural models as explanations of illness and asks how far these models influence the choice of therapeutic procedures.

The basic hypothesis behind the research is twofold, namely, that in Western societies:

(i) What people say about illness is often an idiom in which they express the tensions between individuals and groups. Talk about illness can be a figure of speech in which social disorder is transposed to a particular part of the body, and the aim of therapeutic procedures may be to pin accusations on people considered responsible for the social disorder. The way people talk about illness is a kind of code, determined both by the cultural situation of the persons concerned and by the social context in which the illness arises. Accusations of responsibility for illness can take different forms and can operate at different levels. They may be more or less personalized, and more or less diffuse, according to the type of illness, and they can be analyzed at different levels according to whether or not they involve the notion of responsibility.

(ii) These interpretative models, and in particular these accusations, have a role to play in determining the reaction of individuals and their choice of therapy. We shall later define this reaction in terms of "paradoxical strategies".

To avoid all misunderstanding, I may make three points:

(i) In this study I am not trying primarily to describe "Portuguese, or Gypsy, representations of illness". I am attempting to discern people's representations as reconstructions deriving not only from their cultural background but also from their particular experience and from the socio-economic context of their lives.

(ii) The study is not restricted to people of minority cultures living in France

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[4] This perspective has evidently nothing in common with that of a number of American anthropologists who have studied the problem of "health and family" and whose aim was to determine the link between the structures and functions of the sick person's social circle and the onset of the disease. Pilisuk and Froland (1978) undertook to show that the absence of a network of social relations made the individual more vulnerable to disease, and they stress the value of family relationships as an immune system. Hammer (1982 and 1983) examined biological and social processes and showed the impact which social contacts could have on health and illness.

but includes also data from members of French, or Western, culture.
(iii) This scientific stance does not mean that my interest is confined to what are called "popular" beliefs and practices, nor to a rural culture. My interest is not exclusively in practices which may be regarded as relics of ancient beliefs in magic and witchcraft. I wish, initially, to treat both magical and rational approaches to illness as belonging to the same order, since models of interpretation, and particularly of accusation, of which each approach is an expression, go beyond rationality and have little or nothing to do with the biological knowledge of the parties concerned. For my purposes, there is no *a priori* reason for according a different status to the rational and the magico-religious understandings of illness, since both fall under the general category which I may call "victimization".

V. THE METHOD

This research project calls in the first place for a sketch of the community in which it took place, and, in particular, a description of the economic, social and cultural background of episodes of illness. A grasp of his background is essential for understanding the history of the patient and the circumstances of his illness. My interest in the history of the individual also led me to collect patients' personal life-stories. These were of interest to me, not simply as a way of bringing to life a past of which the ethnologist has to be aware, but also because such life-stories constitute the key to understanding the present. For sociological and explanatory purposes, observation of what individuals are actually living involves a consideration of their past. The past is studied not for its own sake but for the sake of its impact on the present. The study of practices and representations relating to an episode of illness has to be conducted within the context of different aspects of the local social life and in the light of the origin and nature of the various socio-cultural groups which go to make up the commune. Such background knowledge is indispensable for an understanding of the social and family relations within the sick person's group and for an appreciation of the modifications to those relations wrought by the new situation of illness.

Secondly, my enquiries were about concrete cases. I was concerned with specific, genuinely or supposedly sick individuals and with their relationship with their whole world of family, socio-cultural group and community, as well as, it may well be, of the wider society. Particular cases are however only regarded as typical when they illustrate phenomena which are found also in other families and exemplify behaviour whose logic can be generalized.

Fabrega (1971) has written of the importance of illness-episodes in helping to discern the factors which, in a given cultural context, define a pathological condition and determine reactions to illness and attempts to cure it. Fabrega also recommends accumulating a number of case-analyses to reveal the logic governing illness-episodes. Different case-histories and illness-events are to be studied over time with the aim of bringing out the essential coherence of the patients' experiences.

In addition to trying to get to know the sick persons themselves, I also sought to make contact with their professional helpers. Occasionally I was able to accompany the doctor on his visits, and I also assisted at a consultation with a female healer. It is of course not easy to win the confidence of people who are devotees of different kinds of medicine simultaneously. For this reason I had to go to a great deal of trouble to explain to my informants the purpose of my research and to make it clear that I was not myself the medical person they would often have liked me to be. I had also to treat as potential informants all

the persons involved in any degree in the case under review: doctors, healers, paramedical personnel, family, friends, neighbours, pharmacist, clergy.

This type of approach is not without difficulties connected in part with the object of the research itself. It may mean asking intimate questions about the body, and an atmosphere of confidence has to be created before the subjects can be expected to co-operate in the research.

My background in African anthropology led me to opt for a type of fieldwork in which I acted as far as possible as a "participant observer". Anything like comprehensive observation in this particular kind of situation is of course very difficult, if only because the individual's residence and place of work are for the most part distinct. It is nevertheless possible to choose to live "on the spot", as in African fieldwork, and so not only become part of the local network of relationships but also be in a position to collect a variety of information, however irrelevant some of it may seem at the time. Such information may be used later for a specifically anthropological reconstruction in terms of kinship networks, relation to space, religious life, associations, systems of thought, and the like.

Because I wanted to be truly immersed in the life of the commune and to observe at first hand the daily life and circumstances of the subjects, I chose to live with a local family.

As I have already stated, I was not trying to construct any radically new methodology, but only applying to another context the method which had guided my African research. Althabe took up residence in a working-class block of flats in order to create relationships between himself and the other occupants. He became himself part of the situation he was studying. In the same way, I lived in La Ville-du-Bois as I did among the Bisa in Burkina Faso, sharing the life of the people and observing their behaviour.

My plan was to change residence from family to family every few months in order to experience different milieux. Evidently I could not live with all the persons among whom I was carrying out research, but living with one family afforded privileged access to a particular network of relatives, friends and neighbours. I made an exception however in the case of the "Travellers". I did not seek to live with them because my presence there would have been conspicuous and might well have marked me out as different. This could have led to an attitude of suspicion on the part of other people and prejudiced my work.

The great advantage of this approach was that it enabled me to observe the subjects at times and in places normally inaccessible to the enquirer. One can pick up all kinds of things at mealtimes or while watching television in the evening, which would never be mentioned in a formal interview.

If the method of participant observation involves sharing the activities of the persons under observation and at least partially living with them, it is not

surprising that initial contacts are, in France, the most difficult, as I shall have occasion to note later. But, surprisingly, it proved easier to practise the method afterwards in France than in a strange culture, for it is very difficult to take part in the activities of a culture to which one does not oneself belong. This applies particularly to an African culture, for historical rather than cultural reasons. My attempts to join Bisa women in preparing meals in the kitchen served paradoxically to underline my difference rather than to integrate me in the group, for the strange sight of a white woman trying clumsily to pound millet made her very conspicuous. In France however people found it quite natural when I offered to join with the subjects in peeling the potatoes or preparing coffee.

Althabe (1977) has raised the problem of the presence of the ethnologist among the subjects he or she is studying.[5] I see the problem somewhat differently from him. Althabe is right to note that an ethnologist easily feels at home in an African village because the colonial past bestows upon him special authority and prestige. It should be added that money is an important factor also.

Generally speaking the ethnologist in Africa is warmly welcomed and served with much consideration, on the level of information as well as on the level of material matters.[6] It is not by mere accident that ethnologists are often called "patron" (= "boss"), even if it makes some happy and others uncomfortable to be treated as what Evans-Pritchard called "superior beings" (1968, p. 30), or as representatives of what Leclerc called "the all-conquering Western civilization" (1979, p. 130).

In a low-cost housing estate however the ethnologist enjoys no such automatic prestige, and she has to explain the meaning of her presence. Althabe used an opportunity which chance put in his way. Some empty premises were being converted into a house for young people and he joined social workers who were organizing meetings to discuss the project. His connection with these social workers allowed him to make useful contacts with the inhabitants, since the future of the premises led families to speak of their relations with neighbours and with others in the flats.

My particular project however made it impossible for me to present myself as a social worker, although at the beginning some families treated me as such. It was noteworthy that the less favoured groups, especially the Portuguese and Gypsies, had difficulty in accepting that I was coming to their homes to talk

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[5] If I feel obliged to differ from Althabe, himself a former student of Africa, I would nevertheless wish to pay tribute to his pioneering role in what anthropologists are accustomed to call "reconversion". At the same time I do not regard the particular term as appropriate, since it obscures the fact that changing the terrain may very well prove to be revealing by bringing out new continuities. In that sense it may be genuinely heuristic.

[6] There are exceptions, e.g. Maurice Duval (1986).

with them about their illness or misfortune without seeking to solve their immediate difficulties concerning housing, administrative problems, employment, social security, school failure, delinquency, and the like. I had however to refuse to be treated as a social worker for two reasons. In the first place, such a label would have made me the recipient of requests to which I could not in conscience respond and which, even had I tried to do so, would have interfered with my research, for this demanded a long period of observation and could not be carried out under false pretences. Secondly, to be taken for a social worker would have involved the risk of being denied certain information, for I soon perceived that there are things one does not say to government agents, which is how people see social workers.

The problem was therefore, how should I introduce myself? It was a problem of importance since on its solution depended the possibility of justifying my questions. As we have seen, if the observer seeks to gain advantage by assimilating himself to the members of some other professional sector, like social work, he must be very careful not to suffer from the prejudice which may attach to this association. Similarly, the anthropologist who is studying different types of therapeutic procedures must make it very clear that he or she is not a doctor or a health official, for while such a misunderstanding might open certain doors to him it would also infallibly close others. People would be unwilling, for example, to talk to a medical professional about their recourse to alternative medicine. In fact not all the families with which I was involved regarded me as a public official of some kind. I met with a variety of reactions when I knocked on doors. In this connection it is to be observed that anthropological enquiry is to a large extent coloured by the historical and social context in which it takes place. In my particular case, preoccupation with security, at least in the peri-urban milieu, means that anthropologists are initially victims of the fantasy of the Aggressive Outsider, and a great deal of mistrust has to be overcome before they can gain access to information.

It is therefore essential to be introduced. Even this however only displaces the problem, for one has also to consider how to present oneself to the potential "introducers".

In all cases the observer is obliged to present his credentials and to state his precise profession. This is the first difficulty. If he says that he is an ethnologist, he will very likely find himself directed to the Portuguese and Gypsies, since these are regarded as the only suitable objects for research by those who think that, even if the ethnologist is not working abroad among "savages", he is still only interested in the strange and the exotic. It is not possible to make enquiries among people who think that they are being taken for "savages".

If the appellation "ethnologist" is to be avoided, those of "sociologist" or "investigator" are hardly more acceptable, for many families complain that

such titles are often used to hide sinister designs. I heard of a person who pretended that he had been sent by a government department to check the quality of the local water, when in fact all he wanted to do was to sell people water-softening devices. Another appeared with the story that he had been sent by the local authority to look into the housing conditions of elderly people. He said that he needed to measure internal walls in order to plan renovations, and having gained entry into the flat of an elderly woman proceeded to rob her of her savings.

To present oneself therefore as an "investigator" is to run the risk of being taken for a salesman or a house-breaker. The very word "investigation" sends a shiver down the spine of many of the people in La Ville-du-Bois, for they tend to associate it with money-collection of one kind or another.

After two incidents of house-breaking within a few weeks, the local authority instructed its tenants not to open their doors to people claiming to be investigators. People were told that the enquiry ordered by the Housing Authority some months previously in connection with the project for renewing old buildings had been completed.

One possible solution would have been to seek the co-operation of the local authority itself in presenting myself. It was however a solution which I preferred to avoid, since the Communist bias of the authority was not to everyone's liking. To have presented myself under the aegis of the local government would have meant "classifying" myself in the eyes of families, whereas my position as ethnologist demanded that I remain as neutral as possible at every level.[7]

In the end therefore there was only one possibility, namely, to present myself honestly as an anthropologist. There was the risk of being misunderstood, but there was also the advantage that the term was probably

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[7] This principle of neutrality does not apply only to the political stance of the ethnologist but to anything which might distance him from the persons he is studying. Such things as ideological and religious divisions, attitudes to health, and differences in value-systems, may in fact be more serious obstacles to the research-worker at home than the obvious cultural differences which a Western observer encounters when he is working in traditional African societies.
There can be situations in which the ideal of impersonal neutrality can hardly be maintained. Sometimes such close personal relationships will be established that the observer will be obliged to speak of himself or herself. I may mention my own experience when I was expecting a child and, resting briefly in the local square, met another woman in the same situation. This community of experience - bodily, individual and social - created a natural bond which dissipated all distrust and gave me an entry into the other woman's family. But of course an anthropologist cannot choose pregnancy as part of the scientific method. What one can choose however is to give oneself completely to the milieu and be prepared, if the opportunity presents itself, to exchange personal confidences with another, while preserving what we may call, to borrow a term from Max Weber, the "<axiological neutrality> of fieldwork", so as not to project one's own representations onto one's interlocutor.

unknown to the subjects and aroused their curiosity. This was the course I finally adopted, after many false starts due to an initial reluctance to use a term with which few people were familiar.

I may conclude this chapter with a remark on the pretended absence of "distance" between the observer and his subject when he is working in a Western society. Sindzingre has spoken of the connection between the sense of strangeness and the length of the anthropologist's sojourn in a foreign milieu: the longer he stays, the less strange he feels (1986, 53). It seems to me that in the West the situation is exactly the opposite. When the anthropologist is operating on his own home ground, he is likely to experience initial discomfort, not because he is personally known but because he feels culturally close to the subjects of his study. As his observation proceeds however, this discomfort is alleviated by his growing perception of the distance which in fact separates him from the people he is studying.

VI. ASPECTS OF LIFE IN *LA VILLE-DU-BOIS*

I offer in this chapter a sketch of the life of *La Ville-du-Bois*: its recent history, its socio-economic characteristics, its urbanization, and the leading features of its inhabitants. I also give a survey of local life, so that the reader may better appreciate both the data which I collected and the analyses proposed later on in the work.

The history of the population of the commune is bound up with that of the different groups which live there. Some, the original market-gardeners, have lost their rural milieu as a result of the intense urbanization of the Paris region. Others, especially those working in the service sector, have rather lost their urban milieu, being driven by economic necessity to the outer fringe of the capital. Others again, like the Portuguese, are simple immigrants, while the Gypsies and Yenishes are nomadic peoples who have for the most part now adopted a sedentary way of life.

La Ville-du-Bois thus provides a home for very different kinds of people who have found their way there by various types of migration. The only original inhabitants are the market-gardeners and their families.

At the beginning of the century, market gardening was the commune's principal activity and its produce was sent to the Paris vegetable markets. Little by little this activity declined, and many of the market-gardeners were obliged to seek supplementary employment as cleaners, nurses or occasional workers in the Psychiatric Hospital of Vaucluse, in the neighbouring commune of Ste-Geneviève-des-Bois. Today there are about fifty farmers and some thirty agricultural labourers.

In the 1920's the possibilities of agricultural employment attracted a number of Polish workers, as well as some Czechs, and the local farmers formed several alliances with these newcomers. At the same time the municipality subsidized the settlement of a community of Gypsies and Yenishes who had come to the area while the market gardens were flourishing and who provided a pool of seasonal labour. Most of these nomadic people became sedentary during the Second World War, when a number of them were interned by the Germans in a temporary camp around the race-track of Montlhéry. Others had come to the region after being expelled from the nearby Paris suburb. Some nomadic people also settled in the neighbouring communes of Linas, Nozay and Marcoussis for the same reason. Most of these "Travelling People", officially estimated to number over three hundred, no longer travel. There are today only a few nomadic families left. They occupy plots of communal land during the winter months, while the rest live in caravans on land bought from the commune and find employment mostly in public works and in rubbish collection.

The need for immigrant labour in the 1960's attracted a large number of Portuguese who eventually came to constitute the largest section of the local labouring population.

The last two decades have seen the arrival of a growing number of people from different parts of France, including Normandy and Brittany, but especially from the Paris region, either from the communes to the north of La Ville-du-Bois or from the city itself. These latest arrivals were attracted especially by the comparatively low price of land in the commune and their ambition was to build their own homes. This phenomenon was part of a national trend towards private ownership which reached significant proportions in the 1970's. Between 1968 and 1976, La Ville-du-Bois issued some fifty building permits per year, and the population of the commune doubled in twenty years, from two thousand in 1962 to four thousand in 1982. By 1988 it was five thousand. The result has been the erosion of communal land and a massive housing development around the original centre of the old village. These houses are for the most part not second homes but principal residences. In 1982 these constituted 92% of the total, and half of them dated from after 1974. 80% are owner-occupied.

While the majority of the population is still composed of labourers and employees of different kinds, including low-paid clerical workers, there is an increasing proportion of middle- and upper-class professionals. This shift is due both to the cheap price of land and to the growing shortage of building plots. One can foresee that the urbanization of La Ville-du-Bois will soon reach saturation point.

The choice for building affects particularly young married couples of about twenty-five. They are often people of modest means and their desire to have their own home may lead them to incur serious debts which they cannot repay. The resulting difficulties are often blamed by their neighbours for the high incidence of divorce. It should be added that these newcomers, as they are considered by the older inhabitants, are attracted to La Ville-du-Bois, not only by the desire to build their own home, but also by the idea of "living in the country". Some of them wish to escape from city life, Paris in particular being regarded as unhealthy, the source of nervous illness, depression, stress, loneliness, suicides, pollution, and noise.

There are therefore all kinds of people in the commune, differing both in history and in cultural and socio-economic circumstances.

To some extent the different sections of the population live in their own separate areas. Thus the "old centre", the original village, is inhabited for the most part by the families of the original market-gardeners and by Portuguese. There is an economic explanation for this. The price per square metre is lower in the centre than on the outskirts and the old buildings are skilfully renovated by the Portuguese, who are expert builders. The people living here tend to be

rather elderly: 40% are over sixty, and 30% between forty and sixty. The outer areas are inhabited especially by "the newcomers". They live in detached houses on more spacious plots which in some places abut on pieces of land classified as unsuitable for building, mostly on the edge of woodland, and occupied by the caravans of Gypsies and Yenishes.

The relations between these different groups are strained. The Portuguese community, representing about 15% of the population, is regarded by the rest of the people as a real "foreign body" which has come and attached itself to the commune. People say that they are shut in on themselves, that they think they are still in Portugal, that they do not even try to live like French people or to speak French. It is clear that we have to do here with a cultural difference involving different rules and different styles of life which the local people find offensive. The village people speak of the "invasion" of the old centre by the Portuguese, saying that the old High Street which, with the main square, contains practically the whole of the business sector, has been "colonized" by the Portuguese. The feeling of having been invaded is reflected in the widely-differing statistics given for the number of Portuguese: the greater the hostility felt towards them, the more numerous they are said to be.

The other local people refer to all those coming from Portugal as "Portuguese", but they make a distinction according to the degree of foreigness. There are those whom one speaks to and who are scarcely perceived as Portuguese, and there are those with whom one has nothing to do. Otherness is estimated in terms of perceived foreigness, although one may wonder about what exactly is perceived and what underlies the perception.

In fact, beyond all cultural differences and consequent styles of life, there is a fundamental dimension which tends to reinforce the distance between the different categories. This is each category's relation to space, or, more exactly, where people live.

Continual reminders that people come from elsewhere increase the sense that they are "different". The prime difference between the "visible Portuguese" and "assimilated Portuguese" is that they speak different languages. The language barrier increases the sense of difference, not only because it is an obstacle to communication but also because it is a constant reminder of the different origin of the Portuguese. They are felt as coming from elsewhere because "they do not even try to speak French, they think they are still in Portugal."

In this connection it is noteworthy that young Portuguese are reluctant to follow the courses in the Portuguese language organized by the municipality at the request of parents. The young refuse in this way to be classified as "other". They were born in France, they consider themselves French, and in France one does not speak Portuguese. In this way the young are in opposition to their parents who try to create a special Portuguese space by regularly reading

Portuguese newspapers.

French people are also reminded that the Portuguese do not really belong by the latter's habit of growing in their gardens vegetables like certain varieties of cabbage which are hardly known in France. The women often dress in black and people say, "You would think you were in Portugal." The difference between the groups is therefore not simply a matter of cultural distance or proximity but is also connected with the relation which each has with places and with the commune, in short with living-space.

One sees this in the different attitudes of the native French to even the assimilated Portuguese on the one hand and the Poles on the other. Both groups may speak French and live like French people, but they are regarded as radically different because the Portuguese regularly go home to visit Portugal while the Poles seem to have broken off all contact with their country of origin. The continual trips abroad constitute reminders of an alien origin and have a cultural as well as a spatial implication. They are felt as a standing sign that even assimilated Portuguese remain fundamentally "other". "They have never really adopted France, and anyway they go home every two years," say the irritated villagers.

The general picture is that the "good" foreigner is the one who is becoming less of a foreigner, the one, that is, who does not seek to retain links with his place of origin, the one who makes you forget that he comes from somewhere else. It is true that the Polish immigration is older than the Portuguese, and one might imagine that it is only natural for the Poles to be by now more accepted than the Portuguese. Time is on their side. It is however by no means clear that it is simply a matter of time. The question of space, especially living-space, appears to be equally decisive. The actual date of an immigrant community's arrival plays little part in the mental representation of the foreigner, for objective criteria have little to do with this representation. I take as proof of this assertion the fact that the Yenishes and Gypsies came to La Ville-du-Bois long before the Portuguese and even before the Poles, but they are still firmly classified as "other". "Travelling People" may have French nationality, they may have lived for decades in the area and for centuries in France, but they are still regarded as radically foreign. It is interesting to observe that while they may sometimes be called Manouches or Romanies, they are far more often referred to as "the Travellers" or "the Travelling People". What makes the case of these people even more interesting is that most of them are not travellers at all. They do not practise the nomadic kind of life which could arouse anxiety in the social imagination of the sedentary inhabitants of La Ville-du-Bois. These "Travellers" do not travel. Yet they are still perceived as foreigners because their living in caravans relates them to a space outside the point of reference which is the commune. Moreover the common appellation "Travellers", whether it is given to them by outsiders or

used by themselves[8], obliterates all "ethnic" differences between the various groups concerned and denotes only their common spatial eccentricity, namely, their living in caravans. The name does not mean only "those with a strange way of life" but denotes a group identity based on a specific relation to space.

People's talk about "the Travellers" is strongly marked by feelings of insecurity, connected with the sense of the other's strangeness expressed in residence. Here again one may remark that the Yenishes regard themselves simply as local people and reject any non-French origin. They consider the Manouches as foreigners, while these for their part regard the Portuguese as invaders, complaining at the same time that these invaders enjoy more rights and favours than themselves, although they do not have French nationality and have only been in France for a short time.

It seems that people are always looking for someone "more foreign" than themselves, especially someone "stranger" to the commune. Once one has succeeded in identifying such persons, the difference is felt to legitimise one's own right of residence, and it is expressed in "distance behaviour" in daily life.

At the same time this exclusion, this inscription in the register of the other, is by no means solely a matter of ethnicity. Cultural otherness and the type of relations to which it leads may coincide with spatial difference in terms of residence, but it is essentially a social construction and cannot be measured by objective criteria like different language, beliefs and customs. As the French feel that the Portuguese are "invaders", so the old families of La Ville-du-Bois regard as intruders the "newcomers", as they call those recently arrived in the commune and coming from other communes or departments, especially the city.

The older inhabitants have many grievances, but they blame the arrival of the newcomers especially for the general degradation of relationships in the commune and for the fact that they themselves no longer feel at home there. They are "selfish", these new arrivals, "they have no sense of solidarity, they are killing the life of the commune": and all this because "they have no roots". "They do not live like us," says one of the older inhabitants, and he speaks of the newcomers as "ill-matched pieces". No doubt in part these are criticisms of an unacceptable city style of life, but what especially angers the old people of La Ville-du-Bois is that the newcomers with their different culture are just using La Ville-du-Bois as a dormitory. Here too cultural distance generates feelings of insecurity about people who come from elsewhere and go off somewhere every day. They are not really known and therefore felt as a danger and a threat. As for the newcomers themselves they are not short of a

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[8] On the demand of the people themselves to be called "Travellers", see P. Williams: "To say that one is a Traveller means to say in the first place, and perhaps only, that one is not *Gadjo*. This is the real meaning of the word "Traveller", and this is why Manouches, Yenishes, Gitanos and Romanies prefer it to other names. It is not to be

response. If the old inhabitants blame them for lacking roots, they in turn regard the former with compassion or contempt as poor creatures with a parish-pump mentality: they have not travelled, and may never have put a foot outside La Ville-du-Bois.

What is also quite remarkable is that within the category of "newcomers" itself there are similar distinctions, based on the relations between the individual and the space of the commune. A man may have lived in La Ville-du-Bois for twenty-five years, but he is still regarded with suspicion by the "pure-blooded" old families: he is not one of them. The same person will however entertain similar sentiments of suspicion and hostility towards another resident who has only been in the commune for five or ten years. "Newcomer" is a relative term, and everyone can always find someone "newer" than himself, just as everyone wants to find someone "more foreign" than himself. In general, length of residence is considered to bestow superior legitimacy.

A variety of considerations therefore contribute to the image of "the stranger" which determines specific relationships. The fact that the "culturally other" can be so variously defined shows that it is a mental construction. The basic formula may be expressed thus: "familiarity with the commune, or long residence in the commune, implies cultural proximity or affinity;" but the formula is applied to different cases with great flexibility. The Other is the one who speaks differently, dresses differently, lives in a different kind of residence: a newcomer's bungalow, for example, or a Traveller's caravan. Above all he is the one who is continually reminding you that he comes from elsewhere. In these circumstances one can understand that the most rejected people, the Yenishes and the Gypsies, continue to be called "Travellers" although they no longer travel. More than designating a style of life, "Traveller" means "radically different" in terms of the space of the commune, of which caravan-living is the great sign. To call them "Travelling People" is to place them firmly within the category of "Other" and to justify an attitude of hostility and suspicion towards them.

On the principle that there is always someone lower than oneself, each social category constructs its own "outsiders", largely defined in terms of residence, whom it fears and about whom it complains. The ultimate Outsider, as far as the inhabitants of La Ville-du-Bois are concerned, is the Manouche living elsewhere in a neighbouring commune. Such a one is regarded as even more dangerous than the Manouches living in La Ville-du-Bois itself, and when a crime is reported he is the first to be suspected.

The logic of these representations produces a pattern of relationships based on social and material space: the importance of residence and of kinds of behaviour is that they can be used to define one's own territory and to exclude

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taken literally, since many of the 'Travellers' do not travel" (in *Liégeois* 1981).

others. The relations between the different social categories are therefore above all relations of avoidance. If physical proximity makes some kind of relationship inevitable, an attempt will be made to restore the distance by erecting a real or symbolic barrier between oneself and the other. Rejection of one category by another involves therefore a variety of avoidance strategies, depending on the intensity of the feeling of fear induced by contact with the particular other. Attempts to move house are expressions of people's desire to live near those to whom they feel close. So some families living in the old centre dream of moving to the residential outskirts of La Ville-du-Bois, or even of leaving the commune altogether, in order to get away from the Portuguese. The cost of such an operation however means that for the most part the dream can never become a reality. Again, French or Portuguese want to build their houses a bit further out when their present residences give onto land occupied by the "Travellers" and their caravans, a view which those living in their own houses find highly disagreeable. People might want to take their children away from the public school and transfer them to a private religious school where fees limit the kind of pupils admitted, on the grounds that there are too many immigrants in the state school. The Youth Centre established by the municipality has had little success because many families do not wish their children to mix with those they regard as undesirable, dangerous and even subversive. Attendance at entertainments provided during the annual feast organized by the Municipality is dropping year by year because of the damage which people say is being caused by outsiders.

Occasional attempts to bring the different communities together have not been successful. The Portuguese set up a Franco-Portuguese association to make their culture and especially their traditional feasts known to French people. The wider aim was to promote contacts between the two communities, but in fact the Association was "Franco" only in name, for not a single French person joined. There is a Centre for the Elderly which is ignored by the traditional families because it has been invaded by "newcomers".

There may also be finally symbolic avoidance behaviour. One old family closed the shutters and boarded up a room giving onto a street which it regarded as hostile because inhabited by newcomers. In general the other, coming from elsewhere, is regarded as contaminated, the carrier of pollution, and contact with such a one is considered dangerous or harmful. Even avoidance relationships however are not free of conflict. Quarrels leading to acts of violence are not uncommon, for example, in cafés frequented by "Travellers" and Portuguese, each group considering that it has prior rights.

The truth is that the differences according to which each group defines the other are based on modes of living and thinking characteristic of distinct socio-cultural groups. One may therefore justly speak of relationships which are "intercultural" and not just "interethnic". If the relationships between

ethnic groups sometimes appear more conflictual than others, this is because they involve a sharper perception of "otherness", based essentially on difference of residence. Otherness, especially cultural otherness, may be expressed in terms of places and residence which are the product of history and mode of life; but this does not imply any real coincidence between different geographical and cultural territories. The situation is rather that each cultural group tends to build on and to associate with a particular territorial group, whether the sought-after affinity there is mythical or real. The image of the culturally other is being continuously constructed anew and it goes far beyond strictly ethnic categories. It is no doubt connected with the socio-economic situation of the persons concerned, who are more aware of group-distance and of avoidance behaviour than of ethnic identity. Nevertheless, objective patterns of behaviour are not sufficient to explain the relationship with the other in a particular place and time. This can only be explained in terms of a symbolic system which stamps everything with a specific mark. In La Ville-du-Bois it is essentially the relationship with space which creates differences between the different cultural groups. The space of reference is the commune, it is this which gives identity, so that being in default with regard to this space, i.e., coming from elsewhere, means belonging to the other.

One could quote many examples of how the opposition between the different social categories finds objective expression in the relation to space, especially to what is perceived as one's own legitimate space. I only cite a few facts to indicate the symbolic system underlying the conflictual relationship.

Avoidance and mistrust characterise the relationships between the members of different categories. Avoidance of the mysterious, unknown other is strikingly expressed by the reluctance of the inhabitants of the commune to use a pedestrian underpass which connects the two sides of Route Nationale 20. Although no violent incident within this passage has ever been reported, it is regarded as dangerous. Dark and unfamiliar, it is the place of strangeness, in opposition to the Route Nationale itself which is in the open air and is a familiar part of the daily scenery. The crossing on the road itself is not marked and it has been the site of several fatal accidents; but people living on either side still prefer to use it. We have here an example of a non-rational, spatial symbolism which explains the fear of underground aggression. The above and the below signify the known and the unknown, the familiar and the strange. The relation to space incarnates and reflects the relation to the individual. Everyone imagines the potential underground aggressor as a member of a group regarded as stranger than his own. Places as such are marked with a positive or negative character. This phenomenon may also be illustrated by an episode in neighbourhood relations which took place in La Ville-du-Bois.

A dispute broke out one day between two neighbouring families, one of ancient stock and one of newcomers. The subject was noise. The newcomers, of

urban origin, attached great importance to peace and quiet. They considered that the countryside should be above all a place of calm, and they complained that their neighbours were allowing their dog to bark all day and that they themselves could not enjoy the peaceful Sundays to which they aspired. The old family for its part blamed the newcomers for the noise. If their dog was barking, they said, it was because the newcomers were feeding stray cats which, attracted by the food, were running along the wall which separated the two gardens. They had nothing against cats, they continued, and in fact had one themselves, but this was a house cat, not a stray, and their dog did not bark at it. In this way they legitimised the aggression of their dog against cats which, being strays, did not have rights of residence like house cats. Again, it was being in the wrong place that was blamed. In the imagination of the old family, the opposition between house cats and strays mirrored the opposition in the population of La Ville-du-Bois. The cats, domestic on the one hand and wild on the other, occupied positions in the space of the commune corresponding to the place of the old and the new families respectively. The domestic cats were legitimately present, the strays were not. In addition, the strays represented nomads and the house cats, sedentary residents. The opposition in terms of space thus reflected also the relation between the Travelling People and the rest.

The cat episode brings out the inside/outside opposition which is of the same order as the below/above symbolism expressed by the attitude to the underground passage. "Inside" is good, it stands for home, for the known, the familiar, in opposition to "outside" which is bad, strange, unknown.

+	–
Inside	Outside
Above	Below

This marking out of space corresponds to how people perceive the commune: the plus sign means legitimacy.[9]

[9] In a somewhat similar way, a man may feel that an outsider, a culturally "other", is invading his own territory. He might be annoyed with such a one when he is obliged to step off the pavement in order to avoid a group of two or three people who are engaged in conversation. The pavement is here the legitimate space, to which those who feel that they "belong" have a prior right, and they feel it an offence when they have to step into

The notion of cultural affinity is extremely fluid and varies according to the historical and socio-economic context. There can be no abstract definition. Intercultural relations cannot be studied uniquely on the basis of what is called "culture" by anthropologists. They can only be understood on the basis of the representations of "the culturally other" fashioned by individuals or groups, and in the light of how they come to construct them. It emerges from this study that the construction is made on the basis of place, residence and habits of travel. One may group these aspects together as a relation to space which treats the commune as an entity which one would like to be close and homogeneous but which is more and more assuming the character of a town, subject to the movements of heterogeneous populations. It may be that the importance attached to the space of the commune is peculiar to the peri-urban situation and to people who have a need for a spatial identity. However this may be, each category clearly constructs his own image of the stranger, his personal "other", in terms of the latter's relationship to the space of the commune. The market-gardeners blame the "newcomers", that is, everyone except themselves, for the depersonalization of the relations between the inhabitants. The newly-arrived French people, while making distinctions between themselves on the basis of time of arrival, reject the "foreigners", who include Manouches, Roms and Portuguese. The Portuguese for their part are suspicious of "the Travellers", and these in turn make distinctions between Manouche, French and other kinds of Travellers[10].

This construction of the culturally other also serves to define and unite the members of the groups which make the construction. The non-indigenous populations are lumped together as "newcomers" by the old families. From the point of view of the market-gardeners, the leading characteristic of all these people is that they are non-native and therefore "other". Similarly the different groups of Gypsies (Roms and Manouches), the Yenishes and itinerants are all called "Travellers" because what sets them apart from others is their habit of living in movable homes.

People may also be given labels in order to identify them as belonging to "us" or "them". Thus the Travelling People, who come from different ethnic groups but share the common characteristic of living in caravans, are all called after certain travelling families, like "the Beckers" or sometimes "the Mullers", even if they are in fact completely unrelated.

Identity may also be indicated by a nickname, and this is particularly true

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the roadway, even when there is no traffic, as there rarely is in La Ville-du-Bois.

[10] The rejection of "newcomers" by the old families of market-gardeners who have lived in the commune for decades finds different expression. The parish priest has been there for ten years, but Mme L. dismisses him as a newcomer who knows nothing of La Ville-du-Bois. His predecessor was "M. le Curé", but this one is only "Jean-Marie Carpentier; profession: priest".

of the old market-gardening families, many of which are connected by marriage. Many individuals may have the same family and even Christian name and they can only be identified by nicknames which are known only to the members of the families. These nicknames provide them with social identity by marking them off as a group from the members of the new families. [11]

As is commonly the case in rural areas,[12] the same family names recur among the older inhabitants of La Ville-du-Bois, and the use of nicknames to designate individuals is widespread. References to the "Travellers" however follow an opposite pattern. It is a curious thing that while people who share the same identity give each other different names, they tend to call all outsiders by the same name, a family name being treated as if it were an ethnic designation ("The Beckers"). The style of naming in this way serves as a cultural indicator. The use of a plural, without any personal name, indicates cultural distance, whereas the use of a family name, individualized by the addition of a nickname, is a mark of cultural proximity.

While the notion of impurity or contamination may be connected with the representation of the cultural Other, and used to justify avoidance behaviour, it should be added that, in spite of the connotations of the word "contamination", it does not imply in this case that strangers are diseased and liable to spread infection.[13] It is true that different groups regard others as in some sense sources of pollution: the old families see the newcomers in this way, the non-Travellers the Travellers, the French the Portuguese. The pollution in question however is rather a matter of style of life, of a strange way of being. The alien culture is felt as something harmful and damaging in itself. I return to this point later.

These tensions, and the way in which they are perceived by the inhabitants of the commune, tend to fashion their interpretation of the behaviour of the local officials. We have mentioned that the Mayor was a Communist and that his relations with some of those under his jurisdiction were not easy. At a

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[11] The funeral of the former director of the Old Peoples' Home, who had also been the headmistress of the local primary school, brought together a number of families from the different socio-cultural categories. It was noticed on this occasion how freely the members of the old families used nicknames in enquiring after each other's news. The impression received was that they took delight in mystifying the "newcomers" who could not understand who was being referred to. It may be added that the origin of these nicknames is either unknown to or forgotten by those who use them.

[12] Cf the findings of research into the style of naming in Europe in *L'Homme*, 1980, 20(4).

[13] On the contrary, it is commonly said of gypsy children that, in spite of their flimsy clothing and lack of medical care, they are never ill. "You see them in the streets in winter, barefoot, with running noses and hardly any clothes, but they are never ill. Perhaps we over-protect our children and that is why they are always sick."

moment when the French Communists and the Church were trying to enter into some kind of dialogue, he organized with the parish priest a project for the renovation of the seventeenth-century church, a project enthusiastically supported by the local authority. The parish priest took the opportunity to propose the restoration of the bell tower and, in accordance with custom, proposed further to name the bells after the oldest and youngest persons whose names appeared in the parish register. The Mayor was glad to accept this suggestion, particularly as it gave him access to Catholic records which he could use to fill in the gaps in the unofficial register of births which he had begun to keep in order to determine the exact number of births in the commune. This was something he could not be sure of, for there is no maternity facility in La Ville-du-Bois and mothers go to Longjumeau where the births are registered. The Mayor decided to go even further and, as a way of helping him to complete his register, offered a set of baby-clothes to families who registered their latest birth. He saw in the principle of naming the bells a way of honouring families who collaborated with him in maintaining his register, and he took the name of the last entry. So the bells were christened Alice, after an old woman belonging to an ancient family, and Guillaume, the son of a "new" couple from the south of France, who have now divorced and left La Ville-du-Bois. This naming procedure was not to everyone's liking, and the elderly Alice in particular was privately indignant that her name had been given to a bell. Nevertheless the bell-naming ceremony was felt by some of the inhabitants to be an expression of the Mayor's desire to find a communal emblem which would help to dissolve the differences between them: differences of age, of social groups, of culture, of length of residence. He wanted, they thought, to bring the whole population together in a single celebration and so exorcize the tensions which were damaging the community.

There is tension between the different sections of the population of La Ville-du-Bois, but there is tension also within each of the sections themselves. In areas where people are building their own houses, for example, families are often at odds with each other over such things as noise, dirt, and general nuisance, especially as they feel that they came to La Ville-du-Bois precisely to get away from these annoyances and to enjoy rural peace.

Before offering a more detailed picture of the population of the private housing estates, it may be noted here that the various tensions in the community inevitably sully the perception which these urban country-dwellers have of their commune. I stressed above the peri-urban nature of La Ville-du-Bois precisely in order to bring out its special characteristics, the motives which brought some of its inhabitants to live there, and the ensuing problems; for all these things are highly relevant to people's experience of illness, connected as this is with local relationships, with representations of the

Other, with the circumstances of life, and with how people see evil, misfortune and ill health.

In their official publications, the municipal authorities like to stress the rural character of La Ville-du-Bois. They habitually refer to it as a village, perhaps in an attempt to encourage the development of warm, family-type relationships in the commune and to make up for the actual tensions, or at least the absence of neighbourliness, between the different social groups[14].

It is difficult to tell from the talk of the inhabitants whether they regard La Ville-du-Bois as a village or as a town. Some people, like a lady secretary who has lived in the commune for fifteen years, regret the absence of facilities, banks, cinemas and secondary schools. You have all these things in a town, she says, showing that, unlike the municipal authorities, she regards La Ville-du-Bois as a village in a derogatory sense. Other people see things differently. The son of one of the market-gardeners says: "I am tired of this Parish Council and its village talk! It is all false. In a village people know each other and visit each other, as we used to do here. Now, with all these newcomers, we have all the drawbacks of a town." His sentiments were echoed by a warning which I received at the beginning of my enquiry from a shopkeeper who had lived in the commune for twenty-five years: "You are going to study La Ville-du-Bois? You are too late. Everything is finished. La Ville-du-Bois no longer exists, it is not at all what it used to be. Everything has gone down the drain since the arrival of these newcomers and foreigners."

No doubt different people see things very differently. It is amusing enough to hear some people speaking of La Ville-du-Bois as "a dormitory town", meaning by this that most people work outside the commune, its economic potential being very low, while walking along streets lined with bungalows and called "Sheep Walk", "Meadow Way", "Cows' Lane", "Marsh Street", "Furze Avenue".

The ambiguous character of the commune, half-rural and half-urban, is also reflected in the way the doctors in the Medical Centre see it from their professional point of view. One of them regards himself as a country practitioner whose task is to treat acute cases, and who has difficulty in persuading certain patients to go to the hospital. In fact most of his patients are from the old market-gardening families, and they regard the hospital as a death-house. Another doctor sees himself as a town physician, which means for him having a more regular clientèle, with chronic patients and cases of so-called town diseases like "depression". He speaks of the "newcomers" who, it

[14] The local authority is proud of the picturesque old wash-house in the centre of the old village which it has been careful to preserve. It has also mounted a campaign for the ecological protection of the site as a place of rural beauty under the slogan, "La Ville-du-Bois is not going to become La Ville-sans-Bois", The Town of the Wood is not going to become the Town without Wood.

is thought, suffer from depression because of their financial difficulties. It is strange to find depression classified as a "town illness" when most of those who suffer from it say that it only began when they came to La Ville-du-Bois, which they regard as a village, and started incurring house-building debts.

The people of the private housing estates attach great importance to the external signs of social success, and they are mainly interested in visible, material symbols. Many live in houses which they have had built themselves. The externals of these residences are immaculate, rising over a lawn and a beautiful rose-garden, while the inside may be still unfinished, with walls unplastered and rooms with no furniture. The living room usually has a video-player, but there may be no beds in the bedroom and people sleep on the floor. Paying for the house involves great expense, and people do as much work as they can themselves. Many couples, having left the city to find peace in La Ville-du-Bois, find themselves suffocating in their homes. Women suffer especially and frequent the Medical Centre in tears to be treated for "depression", complaining that their husbands spend the week-ends doing odd jobs on the house while they themselves can never go out. Outings are expensive and they have to pay for the house. They may complain that the work spreads dust everywhere and they have to spend all their free time on housework. These new house-owners may be practically destitute but they still pay for their children's school meals in monthly instalments.

The massive indebtedness of these families constitutes an unhealthy atmosphere in the sense that it causes "depression" and "marriage difficulties" which may drive the unfortunate people to the doctor. Two examples may illustrate the situation.

1) A young woman with crippling financial difficulties one day called on the doctor for advice on how to lose weight. She could no longer get into her trousers, she said, but could not afford to buy new ones because of all the bills that had to be paid. Nor could she at the moment afford to buy any medicines or tonics. The doctor was very disturbed by this tale, but after listening to his patient's complaints felt he could do no more than suggest that she either eat less or agree to buy new trousers.

2) After a violent quarrel, a couple were talking of divorce and one day called on the doctor to expose their problems and seek his advice.

The doctor is thus expected to solve the matrimonial and family problems of his patients, or at least to lend a sympathetic ear to their troubles, in which the individual and the social, the affective, financial, professional, and existential are all mixed up.

The relations between the doctors in the Medical Centre and the local population vary considerably. It would be interesting to ask what exactly determines the choice of a doctor. It happens that within the same family the father goes to Dr X, the mother to Dr Y, and the children to Dr Z. The old

family doctor has then been replaced by each individual's personal doctor.

It is striking to see how many people go to see a specialist when they have functional or organic disorders, but go to the general practitioner when their problems are more social or psychological. F.Muel-Dreyfus has put it neatly: "The general medical practitioner has been more or less displaced by the specialist as far as diagnosis and treatment is concerned. The new emphasis however on the psychological approach to illness in general medicine may be his best opportunity to remain in business. It is further to be observed that, at least in the big cities, the doctor can no longer use the traditional method of personal knowledge of the patient which encouraged people for so long to see him as universal healer" (1984, 71).

In this situation it was not surprising to hear a doctor, who was something of a philosopher, tell me that he was to some extent a priest-substitute. The priest for his part said that he was grateful that there were doctors in the community to take some of the burdens off his own shoulders.

The doctor may be treated as a trusted friend and he is frequently called upon for advice on people's personal lives. At the same time, paradoxically, he may complain that he is no longer the traditional family doctor with whom people forged a personal bond. "Today medicine is a service, and the doctor is like a plumber."

It should be added that the relations between the patients and the doctors of the Medical Centre are by no means always marked by this personal and trusting character. Doctors find certain sections of the population particularly difficult, especially middle-class professionals and, even more, teachers. The doctors complain that medicine has become "vulgarized" and that many patients do not want what the doctor has to offer. They arrive in his surgery with the diagnosis already made and are so sure of themselves that they will argue with him if he attempts to query it, saying that they have read an article about their condition, or seen a programme on television. The problem of course concerns the spread of knowledge and is not confined to the medical institution.[15]

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[15] Relations between doctors and other sections of the population are not necessarily any better. There may be more respect for the doctor on the part of the less well-educated, but this does not mean that trust cannot be destroyed. I may cite the case of Dr Lambert, a jovial character who burst out laughing after hearing what a female patient said while he was conducting a consultation in a "Traveller" district. He had wanted to be simple and relaxed, but his attitude was regarded as disrespectful. The patient's mother-in-law accused him of mockery, put a curse on him, and never called on his services again.

VII. THE ORIENTATION OF THE RESEARCH

Bearing in mind both the general problem as I have exposed it and the results of preliminary observations, I have chosen to approach the subject from a number of different directions connected with certain hypotheses which I shall present as we go along. To simplify the presentation, these hypotheses can be grouped into two principal categories: 1) representations of illness, and 2) practices surrounding illness, although it is clear that the two categories cannot be strictly separated. In a third section I present a further aspect connected with the two previous ones, namely, the relation to the body and the question of effectiveness.

1. The Representations of Illness

Criteria for determining Illness

Jaspers, the philosopher, wrote that the term "sick" expresses "a general concept of non-value which embraces all possible non-values" (1933: 9. Quoted by Canguilhem 1984: 74). An excellent example of this use of the word may be found in the political novel of I. Levin*, The Perfect Day*, in which each character gives a different meaning to the word "sick" according to the position he occupies and the values he espouses.[16] But Jaspers' *dictum* is true of the real as well as of the fictional world.

What has to be examined is, firstly, the kind of context within which a phenomenon or an event is designated as illness by the persons concerned, and, secondly, the meaning and function of this designation. I have had the opportunity of following cases which do not correspond to any medical definition of disease but which are nevertheless regarded as illness by the subjects. My perspective however differs from that of some anthropologists who, while rightly distinguishing the concepts of *disease*, understood as a bio-medical reality, and of *illness*, a personal experience, still tend to regard *illness* as always a response to *disease,* and never therefore conceive of it as a separate and independent phenomenon.

This is the case with Murdock, Wilson and Frederick who write: "Illness serves far better to connote the wider range of phenomena in which we are interested and which may be defined as embracing any impairment of health serious enough to arouse concern, whether it be due to communicable disease, psychosomatic disturbance, organic failure, aggressive assault or alleged accident or supernatural interference" (1978, 450). On this view, *illness*, whatever its cause, is always seen as an alteration and, specifically, an

[16] On this work see Fainzang 1987.

impairment of health.

For Kleinman similarly, "illness includes secondary personal and social *responses* (my italics) to a primary malfunctioning (disease) in the individual's physiological or psychological status (or both)...Illness is the shaping of disease into behaviour and experience. It is created by personal, social and cultural *reactions* to disease" (1980, 72).

It seems to me however that what the anthropologist is interested in, and what must govern his theoretical construction, is not so much the reality of disease as the feelings which the subjects have about it and the analyses which they make of it. There can be representations and even identifications of illness without there being any disease in the medical sense. This by no means necessarily implies any psychic disorder. The point is important, for it is the way in which he perceives and interprets his condition that determines the individual's recourse to therapy.

We may note in this connection that the introduction of a third term, *sickness*, to designate the socio-cultural reality of disease does not really solve the problem of what precisely is the business of the anthropologists in this domain. In order to speak of *sickness*, says A. Young, the sick person or his entourage must translate an experience into a symptom, and this is something which is socially defined. Moreover, according to the same author, the recognition of a state of *sickness* absolves the sick person of responsibility for his abnormal behaviour by transferring it to some other object or person (1976, 15-16). I do not believe that it is possible to express the matter thus, at least as a general principle, since the social recognition of certain illnesses by no means always implies any transfer of responsibility; on the contrary, it may involve blaming the sick person himself for his illness. He may be told that the cause of his illness is his own improper behaviour, as Zempléni (1985: 18-20) showed with reference to exotic societies and, as I shall show later, on the basis of our urbisylvan material.

What is more, the way in which A. Young uses the concept of *sickness* unduly restricts the anthropologist's scope. Some conditions may be perceived as constituting illness by certain individuals, and may involve specific individual or collective interpretation and treatment, without necessarily being similarly recognized by the whole socio-cultural group to which those individuals belong. These conditions would conform to Young's definition of *illness* rather than of *sickness*, but they are still of great ethnological interest, since the representations and practices involved are as much social as individual. Not only have they have both sociological and psychological implications, but they form part of the wider symbolic system which it is precisely the task of the anthropologist to decipher.

I therefore decided to use the term *illness*, though it is of course essential to know the socio-cultural criteria for defining illness. This is especially so in the

context of this research, because a phenomenon which is defined as illness is often a sign of social and, particularly, family disharmony, real or imagined.

It will be clear from the foregoing that from my perspective the categories of illness and of misfortune are in themselves "empty" categories, to be filled by individuals in the light of their own history and culture, and according to their family and social relationships. From this point of view, there is no limit to what may be called illness here, and there is no judgment on it either. This does not imply that I wish to embark on a psychological study, nor that I deny the reality of biological disease. I am only saying that the categories of illness and misfortune are closely connected with the values and representations of the subject's group. (It is striking in this connection to observe how often the notion of "misfortune" is associated by the most recent newcomers to La Ville-du-Bois with the difficulties of starting to build because of the massive indebtedness which this involves.)

As Benoist (1983) justly remarks, in commenting on the work of Good (1977) concerning the various meanings associated with illness, it is true that when one looks into representations of illness one finds oneself collecting more than simply cultural data, for there are variations in the ways in which different individuals see illness. Illness is interpreted according to the cultural model, but it remains a personal experience (p.55). The patient's social and cultural background however provides him with the idiom in which to speak of his illness so that his interpretation, however personal, has an inescapably social dimension.

Interpretative Models of Illness

It is surprising that most of the works which speak about "us" or "our societies", in opposition to "traditional societies", which some are still calling "primitive", seem blithely to assume that all Western people have assimilated the scientific model of medicine now dominant in their culture. This assumption is no doubt due to the fact that in traditional societies there is hardly any distinction between what one may call the lay and the professional understanding of medicine. So Ackerknecht (1971) wrote that "we", unlike "primitives", do not imagine that cancer can be caused by a neighbour's behaviour.[17] Who, one may ask, are the "we" in this kind of talk? If the reference is to the scientifically and medically aware, , then it is a reductionist

[17] "Disease with us is, in the last analysis, a biological, individual and non-moral problem. No guilt is involved when we suffer from hereditary, infectious or degenerative diseases.... If you get appendicitis or cancer, you will never think of associating this with your behaviour towards your neighbour or mother-in-law or your ancestral spirits. We do not usually associate disease with whether or not our personal relations are good, whether we keep certain religious or social rules or not. But this is exactly what the primitive does"(1971: 19).

analysis of the Western sociological reality. The convictions of Western medicine are far from exhausting the representations which Western people have of disease. A study of such representations must include a consideration of a number of ideas which have nothing to do with any bio-medical model. If Ackerknecht's "we" refers to "Westerners" as such, then it is an error, for it is not the case that scientific explanations of illness in Western culture have totally displaced non-scientific representations. I believe on the contrary that the fundamental explanatory models found in the lineage societies of Africa, including in particular explanations in terms of punishment and persecution, are found also in the West, whatever the level of medical knowledge, even if the precise idiom in which they are expressed is different. One may therefore quite properly place in parallel the representations of illness in African lineage societies on the one hand and in Western societies on the other, without being open to the charge of illegitimately juxtaposing genuinely scientific and individual representations, provided of course one makes it clear precisely what it is that one is comparing. In my own case, I have chosen to study representations of illness as these are constructed by the subjects in particular historical and sociological contexts. My interest is in social representations of the causes of illness, whether or not these correspond with what scientific medicine has to say.

One of the major aims of this research is to uncover and to articulate different explanatory models of illness, and especially to show how the incidence of illness sets in train a whole accusation process, as noted above in the discussion of the general problem. I ask furthermore what are the thought-systems which lie behind this reaction and, more generally, what are the conditions for its emergence.

Within this general scheme various questions arise. Is the interpretation of illness connected with the symptoms? Are there symbolic links between the nature of the illness and the causal explanations proposed? I explained above that illness-talk can be understood as an idiom for expressing social tensions. It is now possible to be more precise and to formulate the hypothesis that illness-talk in Western society fulfils the same function as witchcraft in other types of society, although with modifications, by providing an idiom for expressing the tensions between individuals and groups. Both illness-talk and witchcraft-talk are expressions of interpersonal and social conflicts. Studies on witchcraft in both France and Africa (cf. Favret-Saada 1977 and Augé 1979) seem to show that illness-talk and witchcraft-talk both express, in their different, culturally-determined ways, a person's relationship to others and, it may be, his judgment on the nature of that relationship.

The fieldwork I conducted enabled me to perceive how accusations against individuals, or imputations of guilt, operate as factors in the interpretation of illness. Extended observation of life in La Ville-du-Bois showed me how certain

individual and collective patterns of behaviour - such as the attitudes of the different segments of the population towards each other, the use or avoidance of certain services, the relation to space - were bound up with the ideas of misfortune and illness in which interpersonal and inter-group tensions were expressed.

In particular, a deeper study of individual cases showed how responsibility for illness was distributed among different persons, and it also enabled me to perceive the possible meanings of the accusations. In this sense my work served as a kind of counterpoint to that of Herzlich and Pierret (1984) who, in analyzing their interviews, stressed the role of society as the cause of illness. I come back later to this interpretation.

I had earlier begun work in Africa on a study of how the new models of explanation of disease provided by scientific medicine had been integrated into the traditional local explanations (Fainzang 1985). In the course of this work I was led to ask more generally what impact scientific discoveries have on people's subjective representations. What, in short, is the connection between technical knowledge and popular conceptions, and how can two often antagonistic conceptions either continue to co-exist or achieve integration in one direction or the other?

The study of concrete cases made me suspect from the outset that the diagnosis of illness made by those concerned was aimed, not so much at eliminating the evil, as at tackling its presumed cause. An occasional modification dictated by circumstances was all that was required to validate one's interpretation of illness.

Finally the comparative perspective I adopted led me to formulate the hypothesis that there are representations of illness in a Western milieu like that of La Ville-du-Bois which closely parallel those found in the thought-systems of lineage societies (Fainzang 1986). Both associate illness with a fault or with the breaking of a taboo. It will be seen however that this hypothesis cannot be formulated in exactly the same way for all the cultural groups concerned.

2. Illness Behaviour

Therapeutic itineraries

Following the path traced out by the works of Augé, I propose in this study to observe the sick person's "therapeutic itinerary" in order to uncover the different logics behind the recourses chosen and the treatments followed. This question is closely connected with the way in which the patients conceive of their illness, since it is this conception which influences their choice of therapy.

We have therefore to determine what the patient and his entourage regard as illness before we can perceive the coherence of the different steps in the therapeutic process.

I start from the hypothesis that the search for a medical cure cannot be regarded as the only determining factor in the choice of therapy. This choice is also connected with the interpretation of the illness and with the social tensions which that interpretation expresses. On this basis, I study the behaviour of sick people in the context of their personal histories and cultural identity, and in the light of the wider life of the commune. This will lead to a reconstruction of the situation in terms of elements belonging to different levels of social life and thought-systems, and will provide an explanation for paradoxes like the apparent recourse on the part of a patient to what he regards as less effective medical treatment.

To give a properly anthropological answer to the question of what determines the patient's choice of therapy, it is necessary to discern the meeting-points of apparently distinct systems of representation. A careful analysis of what may look like paradoxical strategies, not so much from the point of view of the doctor[18] as from that of the patient himself, should enable us to define models which make sense in terms of culture and thought-systems and which can be associated with other cultural variables.

Given the multi-ethnic character of the commune of La Ville-du-Bois, I wish to examine whether the different socio-cultural categories each have their own specific systems of representation, and their own specific therapeutic strategies. I am also interested in knowing whether there is interaction between the systems of the different groups. Do they borrow from each other?

While it may be difficult to produce a cut-and-dried system of classification associating particular cultures or ethnic groups with particular therapeutic practices, it remains clear that these latter cannot be separated from the wider field of social representations in the culture concerned. Some of them, for example, are wholly based on the theory of double corporeity.

We have therefore to put together the relevant data without prejudicial reference to such dichotomies as rural/urban, traditional/modern, magic/rational.

Processes of Taking charge of a Sick Person

I am also interested in examining the mechanisms which determine who in his

[18] Benoist (1975: 67) has shown how in a polyethnic society like that of the Réunion people have recourse to both modern and traditional therapies. Doctors regard this behaviour as contradictory, but in fact it is based on a strategic policy of taking advantage of what each type of medicine has to offer.

entourage will take charge of the sick person. What are the links between patient and carer? This question will take us into the whole field of family genealogies. The rules governing the process of accepting responsibility for the sick will reveal the nature of the bonds between different kinds of relatives.

Preliminary observation suggests that, when no family is available, bonds of residence and neighbourhood, combined with common work, can replace family responsibility. I may quote the case of an elderly widow whose only son was dead and who had no surviving relatives. She had earned her living as a private tailoress, and today the daughter of one of the families for which she had worked, who lives a hundred yards away, pays her regular visits to give her a bath. Twice a week she brings her soup and she has arranged for her to receive household help from the Red Cross. Another case was that of an elderly unmarried gardener who looked after the rose-trees of a neighbouring family. He had bad eyes, and the family provided him with the daily drops which the doctor prescribed.

What is the logic which reverses the employer-employee relationship by turning the former in a sense into the servant of the latter, while at the same time increasing the employee's dependence? We want to know also what are the conditions and limits of this situation in the different socio-cultural groups.[19]

Prescriptions

Many patients are in no hurry to present to the chemist the prescription they receive from the doctor. Just as in Islamic societies therapeutic powers are attributed to pieces of paper with Koranic verses inscribed on them, so a doctor's prescription seems sometimes to be treated as if it were itself a cure, sharing in the efficacy of the prescribed medicine itself. People may indeed offer explanations for their failure to buy what has been prescribed. They may say, for example, that they cannot afford the cost, which may or may not be reimbursed by the Social Security, or that they have forgotten. But we need to look beyond such explanations. Health workers are well acquainted with the phenomenon of patients who demand medicines, sometimes in large amounts, when they have no intention of ever using them. The mere fact of possessing a prescription, written on official paper in black ink, and containing a list of medicines or recommendations, often seems to be felt as a step towards a cure.

The social and cultural background of the patient also has an influence on the attitude to prescriptions. We have to ask whether rural people have more veneration than urban people for the written word, and whether French people

[19] It is also to be observed that the creation of a carer-patient relationship within a family may involve an inversion of the authority structure, as in the case of the father of a family who had to submit to dialysis at the hands of his wife three times a week.

are more prone than others to such veneration. And what about the Portuguese and Gypsies? How far does the place of writing in one's original culture, and the degree of one's own familiarity with writing, determine the attitude to a written prescription?

Finally we may ask whether the type of prescription is likely to influence the choice of the carer or of the medicine requested. This question is important in the light of the widespread misconception that so-called "soft medicines" are compounded solely of natural products. In fact the recommendations and prescriptions of some unofficial "healers" involve far more than such products. Some of these healers indeed show considerable ingenuity in using the products of industrial society, as in the case of a healer from Antony who was consulted by a lady from La Ville-du-Bois and who heals her patients by selling them cassettes on which she has recorded songs. The theory is that her voice is the vehicle of a healing fluid, and her prescription is to play the cassette every day at home and so absorb the health-giving fluid.

3. Connected Questions

The Relation to the body

Closely linked to people's attitude to illness is how sick people conceive of their own body, for it is this conception which largely determines their choice of a particular therapeutic institution, as it also influences the kind of treatment offered by that institution.

It very soon became clear to me that some patients regarded their body as a kind of bank-vault containing capital which had to be conserved. They refused any therapy which they felt threatened to erode this capital and preferred some alternative, indirect treatment. We may ask why orthodox medicine, called "allopathic", as distinct from "homoeopathic", should give rise to fear and be perceived as a mutilation.

The way people envisage their body is a matter of cultural definition, and the works of Loux (1978, 1979) have shown how this bodily image leads to specific corporeal practices. In addition, each human person has his or her own private history, indissolubly linked to his family and to the evolution of his particular society (cf. Jodelet 1981, Pouchelle 1984). Any enquiry therefore into the therapeutic practices of the different socio-cultural groups living in this particular commune must include an investigation into how people envisage their body and indeed envisage themselves as persons. What are their concepts of anatomy and physiology? How do they conceive of their body and of the functioning of its organs? How do these concepts affect the way they see illness? How furthermore, in the light of these concepts, do bodily modifications

affect the interpretation of an episode of illness?

Since the manner of envisaging the body is clearly at the root of certain therapeutic practices, I propose also to ask what are the representations which lead some people to consult two different doctors for different disorders, although both of the doctors concerned are general practitioners. What is the basis on which patients divide their organs between different doctors in this way? There will have to be a scrutiny too of the mechanisms which lead a sick person to prefer one type of medicine to another. There was for example a young woman, a practising Catholic from Normandy, who worked in child welfare. She was convinced that she had lung cancer and frequented a female healer who practised a so-called magnetic therapy aimed at drawing out the "badness" which the patient had in her body. We have here a clear echo of a practice well documented in anthropological literature, a mixture of exorcism and purification ritual (Lévi-Strauss 1958, de Heusch 1971, Douglas 1971).

I shall also consider the role of symbolic representations in practices relative to the body, on the hypothesis that patients who are receiving treatment may be simultaneously indulging in practices which have not necessarily been prescribed by the health specialists but may still have ritual therapeutic value.

Finally, I believe that people's conception of their relation to the body is involved even in the way they designate illness. I shall therefore try and show that, if the interpretation of illness is to be understood as a kind of language, the bodily terms it uses are not chosen at random but have symbolic significance.

In this connection, following the suggestions of Héritier (1978, 1984), we may reflect on the semantic content of such terms as fluid, substance, interior, exterior, hot, cold. What associations do these words have for people in the context of illness? The global, anthropological approach should reveal how such terms organize the whole field of symbolic representations. In particular, it will be seen how a person's relation to his or her body has analogies with his or her relation to space and to the Other.

The Question of Effectiveness

There have been a number of ethnological works on the question of effectiveness and in particular on the scope of symbolic effectiveness. The most celebrated of these is Lévi-Strauss 1958. My own work in Africa led me to connect the symbolic effectiveness of a cure with the individual's whole field of representations: his notion of remedy, his representations of animals, trees, healers, the body, his ideas about causality and religion. The effort was to try and determine the logic governing the value which sick people attributed to the treatment they received (Fainzang 1986). As the foregoing exposé will have made clear, exactly the same question arose continually during my research in

La Ville-du-Bois.

The method of "case-study" led me to enquire into why people had recourse to different kinds of medicine - official, parallel, traditional, alternative; but it also led me to examine the different relationships which the sick people had with those who looked after them and how they saw their treatment.

These enquiries also brought me up against the question of self-medication, and I discovered that there are people who at certain periods of the year prefer to prescribe medicines for themselves rather than pass through a doctor. This point deserves to be elucidated, if only because it raises the question of how far people regard health professionals as useful people and, more generally, what they think of the practice and effectiveness of medicine.

Although the recourse to different kinds of therapy evidently implies a judgment on their relative effectiveness, this judgment alone does not seem to explain people's choice. Account has to be taken of the whole field of economics and symbolism which are factors in the different cases studied. This question will arise again in connection with people's attitudes to prescriptions, described above.

At the same time, great care is needed in dealing with the notion of effectiveness. On this point, one may wonder whether the works of Favret-Saada (1977) pay sufficient attention to the categories of evil and misfortune when she is speaking of effectiveness. The fact is that the perception of the effectiveness of therapy is as much an intellectual construction as the illness itself and even, to a certain extent, the cure.

VIII. SOME REFLECTIONS ON FIRST RESEARCH RESULTS

The conclusions I offer here are connected with the general problem of using illness as an opportunity for accusation. I present first the case of a Portuguese family, to which I give the fictitious name of Costuedo. I then consider this case in the light of data from other families belonging to different cultural milieux.

The special interest of this family for my purpose was that it provided a clear example of how illness-talk is a kind of language for expressing social and family tensions and disorders. The father is from a rural background and works as a mason. Mme Costuedo comes originally from a town and she works as a cleaner. There are three children, all at school. Observation of this one family discloses different models for the interpretation of illness, different agents being held responsible according to accusation mechanisms which have to be analyzed.

1. Lucie's Illness

Mr and Mrs Costuedo arrived in France from Portugal in the 1960's. They live in a house which Mr Costuedo built himself. They are Catholics and give their children a religious education, but they are not very regular in their own church-attendance.

Mrs Costuedo has adapted to France better than her husband. She has more contacts than him with local French people like shopkeepers and the children's teachers and she speaks better French. She looks forward to spending the rest of her life in France. Her husband on the other hand is often out of work and dreams of going back to Portugal, of which he has fashioned an idyllic image. Relations between him and his children are strained. He does not approve of modern "youth facilities" and in particular he will not tolerate the freedom which his eldest daughter, Lucie, demands when she wants to go out with her friends. Mrs Costuedo acts as mediator between her husband and children, while generally taking the former's side in front of the latter.

Lucie is studying typing and elementary accounts in a Technical School. Since her father refuses to allow her to go out with her friends, she spends the week-ends shut up in her room.

Lucie's Illness as seen by Mr and Mrs Costuedo

Lucie's parents believe she is sick. They call her illness "the cigarette illness", or "drug illness", and blame it on the young men she meets in the street, especially young "Travellers", the "villains in black leather jackets", who are

regarded as dangerous companions. Mr and Mrs Costuedo suspect them of giving Lucie drugs. Her symptoms are listed as follows: "She is pale, she avoids us, she no longer speaks to us, she does not answer when she is spoken to, she slams doors, she does not do what she is told." The condition thus described, especially the "disobedience" to her parents, clearly manifests a disturbed relationship. "She does not listen to what is said to her," is evidence of a strained relationship. Lucie's illness in fact amounts to a breaking-off of dialogue. "Illness" is the name which her parents give to the disturbed family relationship. They regard as pathological Lucie's violent conduct and her silences, which are different from her previously "normal" behaviour. Mr and Mrs Costuedo in short label as "illness" the disturbance of good order in the family caused by the behaviour of their daughter.

It is no accident that they blame the "Travellers" for the situation. It is a natural consequence of the general socio-cultural relationships between the different social groups present in the commune, and is founded on the image which each group has of some other as potential aggressor. As explained above, the Other, and especially the cultural Other, is the one who brings evil. He is the transmitter of modern ills and must be regarded with suspicion. For Lucie's parents, her frequentation of the "Travellers" is at the root of her trouble, here is the origin of her illness: "they hang about the streets, they wait for the girls coming out of school, they give them drugged cigarettes to smoke." Lucie is only sick because of the "Travellers".

The Therapy for Lucie According to her Parents

Mrs Costuedo wants "to do something" for her daughter. She suggests taking her to the doctor so that he can help her, but Lucie refuses. She protests that, while she may have sampled cannabis, she no longer smokes it. Noticing one day that her daughter was developing pimples, Mrs Costuedo repeated her suggestion of visiting the doctor. She thought at first that it might be indigestion, and asked Lucie what she had been eating. There were no grounds for suspecting anything in that line, and Mrs Costuedo then had no doubt that the pimples were caused by "drugs". The pimples showed that her condition was getting worse and medical help must be sought at once.

What makes Mrs Costuedo even more anxious is that, whatever other people may think, she believes that Lucie is thin and fragile and vulnerable to any worsening of her condition: "She isn't strong, it will not be long before she leaves us" (i.e. she dies), she sighs. But Lucie still refuses to see the doctor. She tells her mother that she feels very well, but at bottom she is afraid of being required to undergo disagreeable treatment, in particular detoxification.

The Recourse to the Seer

Mrs Costuedo is now thoroughly alarmed. Well-intentioned neighbours suggest that she consult a female seer who, they say, has special powers. Mrs Costuedo however is sceptical. She has never visited such persons and has little belief in them. Nevertheless when her Portuguese neighbours insist, she puts the matter to Lucie and suggests that she go to visit the seer who will help her and cure her pimples.

Lucie has no more belief than her mother in the seer's powers, but she agrees to go and see her because of her mother's insistence and to avoid having to go to see the doctor. She is after all on better terms with her mother than with her father and does not wish to alienate her as well. So she goes off to the seer as a concession to her mother, hoping that this will be the end of the endless quarrels about seeing the doctor and that she will now be left in peace.

A further element in Lucie's agreement to visit the seer is that she does not fear her as she does the doctor. "She's not like a doctor, she can't do anything to me. Doctors do all kinds of things to you, they send you to a detoxification centre. I don't like that." We see in these expressions a common view of scientific medicine as likely to have a negative effect on the body, whereas there is nothing to fear in "alternative medicine".[20]

Lucie was more prepared to visit the seer because she did not fear the latter's treatment. A distinction is being drawn between different kinds of medicine in terms of "risk": "there is nothing to lose" in having recourse to alternative medicine. It is significant that this may be referred to as "healing" or even as "soft medicine". Although official medicine is never called "hard medicine", nor referred to as "violent" or "aggressive", it is still often regarded as in some way brutal and destructive. It was this which Lucie was afraid of.

For Mrs Costuedo the consultation with the seer was a second-best solution to the problem. At the same time, in so far as the motive was to cure Lucie's "illness", it represented a victory for the mother over the daughter. Certainly the mother would have preferred the doctor, but she had at least wrung some kind of concession out of her daughter. One of Lucie's "symptoms" was disobedience, but now, says her mother, "for once she agrees to do what I ask." For her the importance of the visit to the seer was that it represented some softening of Lucie's resistance. "Even if I don't believe in it," she says, "I say to myself: it can't do any harm, and we shall see."

The visit to the seer is therefore by no means a simple matter of seeking

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[20] One may quote the case of an elderly market-gardener who suffered from inflammation of the arteries. After medical treatment had failed to bring any improvement in his condition, he decided to visit a "healer": "Why not try it? It can do no harm and there will be no medicines to take. These healers, they are not like doctors, they do not touch you." Recourse to the healer was seen as at least harmless because it did not involve any kind of "aggression" against the body.

medical help. In fact, Mrs Costuedo has much more confidence in the doctor and his prescriptions. Even Lucie, in her fear of the doctor and her refusal to visit him, recognizes his superior knowledge and competence. It is precisely because she has no fear of the seer and no belief in her power that she agrees to the consultation in order to put a stop to her mother's nagging.

We have therefore a paradoxical situation in which both mother and daughter recognize the superior competence of the doctor, though the one seeks it and the other fears it, but both accept the solution of the seer-consultation in order to preserve their relationship. Lucie wishes to silence her mother's complaints and to improve their relationship, and the mother wishes to discharge her conscience by "doing something after all", even if she does not expect any real results. She has the satisfaction and relief of seeing her daughter submitting to her will and resuming the attitude of filial obedience which she expects from her.

There is here a clear gap between theoretical position and actual practice, and one sees also how in the reality of social and family life relationships are more important in the choice of therapy than purely medical considerations.

The Consultation

When Lucie arrives with her mother, the Portuguese seer says to her: "Do not think that I am a witch. I am a professional person." At these words Lucie begins to cry, and the seer continues: "Do not cry, I am going to help you. Tell me why you have come to see me." Lucie does not reply, but Mrs Costuedo explains that her daughter smokes drugs and that this has given her pimples. The seer says that this is for Lucie to say, and turning to the girl asks whether what her mother says is true. Lucie nods. The seer then proceeds to an examination. She looks at Lucie's arms and says that she does not inject herself. Continuing the examination she sees the pimples and agrees that they are the result of smoking drugs. She then takes a crucifix in her hand and utters some words in a low voice which neither Lucie nor her mother can hear or understand. She then makes the girl take a vow not to take drugs any more and gives her some salt, telling her to take a little each evening to cleanse her blood and cure her pimples. There is here an echo of the use of salt in Christian liturgy. It has a healing efficacy and will purify Lucie's blood. One is reminded also of an episode in the Old Testament. When the people of Jericho complained to Elisha that the water of their town was bad, the prophet "went to the spring of water and threw salt in it and said: 'Thus says the Lord, I have made this water wholesome; henceforth neither death nor miscarriage shall come from it.'" (2Kings 2, 20-1).[21] Finally the seer places a large bouquet of

[21] Favret-Saada 1977 similarly noted the frequent use of salt in European practices of exorcism.

roses on the table and explains to Lucie that these flowers were a thanksgiving gift from a young man who had suffered from the same condition as herself and was now cured. Deeply impressed, Lucie leaves.

Some weeks later she says to her mother: "Since I saw this lady, there is something which stops me from smoking drugs. I do not know why, but they mean nothing to me any more." In fact Lucie no longer smokes either drugs or tobacco. Mrs Costuedo is puzzled at the "success" of the seer, and resolves to go and see another similar person next time to compare their practices. "I cannot tell whether she divines or not," she says, "for Lucie told her everything." She admits that people say that the seer cures "serious illness", by which she means illness which doctors cannot cure, but she really attributes Lucie's cure to the fact that she has become "more sensible" and has stopped associating with "the young loafers and Romanies who hang about the streets."

The Situation of the Father

Mr Costuedo, like his wife, puts the blame for Lucie's condition squarely on the company his daughter is keeping, especially the culturally Other, marked out by a different space (the "Travellers"). For him the whole problem is envisaged in terms of this space. His solution to Lucie's illness is to keep her at home so that she can avoid contamination by the alien space which the presence of the Other, the Traveller, renders dangerous. The important thing is to preserve the purity of the domestic space and not allow it to be polluted by the presence of the Other. So he refuses to allow his daughter to go out in her free time, or to let her friends come to visit her. While the mother takes Lucie to a healer on account of her physiological condition, the father's solution is simply to keep her at home and away from the harmful contamination of the Other.

Lucie, on the other hand, wants to get away. She would like to go and live in a boarding school, but her parents refuse. They alleged financial reasons, but in reality they are uneasy at the prospect of losing control over her movements if she leaves the family home. Lucie wants to get away from a family environment which she feels as unhealthy, as we shall see later.

Lucie's Illness According to Lucie

When you ask an individual whether there is anyone sick in his family, and, if so, who, and of what, you get a different answer according to the place which each occupies in the network of family relationships and to the way in which each perceives his relation to the others. When Lucie is asked about her health, she says that she has earache and that she cannot hear properly. She explains this by the slaps her father gives her and which, according to her, are ruining her ears. Her mother rejects this interpretation and produces a family health

certificate which shows that weakness of the ears is congenital in her family. Her own mother, she herself and her two daughters have all been afflicted with this complaint. Her daughters in particular suffered several attacks of otitis in childhood.

Lucie's explanation of her illness allows her to blame what she sees as her father's destructive behaviour. It reflects her perception of her father and of her relationship with him. Her body is the vehicle of an intellectual construction of her conflict with her father. The "earache" is the focus of this construction. Lucie does not deny that she is sick, but the important difference is that for her the illness is not "the cigarette", which she regards as no more than a pastime, but her "earache". As far as Lucie is concerned, her father is destroying her, and she uses complaints about his violence to express her feeling that he is ruining her life and spoiling her relationships outside the family. By the figure of speech known as metonymy, the ear stands for Lucie's body which is the vehicle of protest against her father's destructive behaviour.

The Doctor's Diagnosis

Lucie did in fact visit an ear-specialist who diagnosed otitis and prescribed a treatment which Lucie did not follow. When she returned after three months, the doctor reproached her for her negligence and told her not to come back and blame him if she became deaf.

It is interesting that Lucie refused to follow the ear-treatment. In spite of her fear of doctors, the fact that she visited the ear-specialist showed that she was taking the situation seriously. Her admission that there was something wrong was a way of expressing her resentment of her father's violence. At the same time to have followed the prescribed treatment would have implied acceptance of the diagnosis of the doctor, who himself disagreed with her own diagnosis. In this way, the grounds of her accusation against her father would have been destroyed. In prescribing treatment to cure her condition, the doctor is undermining her complaint against her father, her bodily condition being, from her point of view, the expression of her relationship with her father. To treat her ear would be to destroy the palpable sign of her sense of being the victim of his destructive behaviour. What determines her attitude, therefore, is not the effectiveness or otherwise of the treatment but the desire to find confirmation of the diagnosis which she has herself made of her condition. To follow the treatment would be to contradict that diagnosis. Her behaviour is an expression of her interpretation of her illness.

So Lucie decides to visit another doctor, because she regards this one as

incompetent. This judgment corresponds to the role she expects him to play, namely, to confirm the gravity of the situation for which she holds her father responsible.[22] She is however uncertain about the possibility of finding a complaisant doctor who will deliver her of her trouble, so she says: "In any event, the only thing left is for me to get out of here as soon as I can." The doctor warns her of the danger of deafness if she does not treat her otitis. She converts this warning into an argument about what will happen if she continues to be the object of her father's violence. "He keeps hitting me and hurting my ear, he will end by making me deaf. If I feel one day that I am going deaf, I swear that I will get out of the rotten place altogether."

Leaving home is thus envisaged as the final step in the curing process. To escape total destruction, Lucie will have to get away from the illness environment which is how she sees her home.

We have then two interpretations of Lucie's illness and both refer to the disturbance of family relationships. In each case the interpreter is expressing a conflictual relationship. In each case also the interpretation is accompanied by an act of accusation which reveals the tensions existing between the different members of the family or between the different communities present in the commune. In the eyes of her parents, Lucie is destroying herself by her association with the Other, the outsider, the villain, the Traveller: "It will not be long before she leaves us", says her mother. As far as Lucie is concerned, it is her father who is destroying her. In the one interpretation, the threat comes from outside; in the other it comes from within, from the household itself. The therapies proposed for curing Lucie's illness are radically opposed. Her father's attitude is that she must be rescued from the alien space; Lucie declares that it is from the domestic space that she must escape.

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[22] I may explain here how I understand the notion of responsibility from the point of view of anthropological investigation. Weber made a distinction between subjective meaning, which is the meaning of an event as perceived by the persons involved in it, and the real, objective meaning. Drawing on this distinction, Schutz speaks of the subjective meaning of responsibility, that is, the responsibility which those involved feel for a certain action, and the objective meaning, which is the responsibility as it is perceived by anyone else (1964: 275). If we adopt this terminology, we may say that what interests the anthropologist is the subjective meaning of responsibility for illness. From this point of view, the reality of Mr Costuedo's responsibility for Lucie's disorder, and the connection, possibly objective, between his slaps and Lucie's pain, is irrelevant. The anthropologist is only interested in people's subjective representations..

Lucie's Illness

	According to her parents	**According to Lucie**
Description	"Cigarette-illness"	"Ear-Illness"
Symptoms	"she looks bad" Violence Insubordination Then: Pimples	Earache
Cause	Consorting with "Travellers"	Father's nervousness and violence
Responsible Agent	The Cultural Other	The Near Other
Proposed Cure	By Mrs Costuedo: Recourse to Doctor and then to Seer. By Mr Costuedo: Confinement (so as to avoid Outside Space)	By Lucie: Recourse to "Ear Doctor". Go into boarding school, then escape from home, so as to avoid domestic space.

There are thus two distinct and opposed schemas of Lucie's illness. In the first case it is the father (near relative) who is responsible for Lucie's illness (earache). The accusation expresses the relation of the victim to the accused, in this case a conflictual relationship. In the second case, the one responsible for Lucie's illness ("Cigarette") is the Other (Traveller, stranger, the unknown). He is the Distant Other, the one whom one avoids. He is the prime suspect precisely because he is unknown, the focus of all the fantasies which ignorance bestows on the Cultural Other.

Two images of the other emerge from this analysis. In my further reflection I shall call them for convenience' sake the Near and the Far Other respectively.

The Father's Illness

I examine here a third category of illness as this is constructed by the subjects. Its interpretation constitutes a kind of synthesis of representations emerging from distinct cultural systems. When Lucie considers her father's attitude to

her, she thinks he is very nervous, "he suffers from 'nerves' and that is why he keeps hitting me."

Mrs Costuedo is also troubled by her husband's violence towards his daughter, whose attitude of rebellion she says that she sometimes understands. She also thinks that her husband suffers from "nerves" and says: "Perhaps it is because life is difficult in France, with all the unemployment and everything." Here the explanation of the violence in the house moves up a dimension to society itself.

The interpretation of the father's illness thus gives rise to a series of accusations whose function is to determine who is responsible. Mrs Costuedo finds a supplementary category of cause in society. What is interesting about Mrs Costuedo's remarks about her husband's "nerves" is that it brings together elements from her own cultural background and representations arising from her experience of the French context. There is in Portuguese representations of illness a specific category called "nervos" which designates disturbed behaviour and is generally associated with family troubles. The same category is found in related cultures. Setha Low (1981) found it in Costa Rica, and we hear of "nervios" in Mexico, Colombia and Nicaragua, where it is also associated with a rupture in family relationships. The symptom of this condition is "loss of control caused by difficult family relationships". Its cultural significance, according to Setha Low (1981, 37), is that it expresses the opposite of a healthy, family-based life as prescribed by Costa Rican values.

The use which Mrs Costuedo makes of the expression "nerves", and the cause to which she attributes it in her husband's case, combines two cultural systems. She is using an illness-category from her original culture (*nervos*, cultural symbol of family troubles), and applying to it a cause derived from a system of representations in contemporary Western culture, where evils are often associated with what is called "Society".

However, while Mrs Costuedo reproaches Mr Costuedo for his "nervousness" and violence, Mr Costuedo, who does not deny the accusation, blames her. If he is nervous, he says, it is his wife's fault because she refuses to return to Portugal. In his view, everything would go better if they lived there. Husband and wife thus accuse each other. It is a closed circle.

On the other hand, when Mr Costuedo blamed his wife for his violence towards his daughter, she confided to me: "After all, it is perhaps partly my fault. It is true that I am the one who wants to stay in France. I think it is better for the children." Here we have a fourth accused in the accusation process: herself. This is the model of self-accusation.

In this example responsibility is attributed to four different agents. We find in fact here four models of accusation:

1. Self-accusation;
2. Blaming a near neighbour (member of the family, a known person with

whom there is a conflictual relationship);
3. Blaming a far neighbour (stranger, anonymous, unknown, with whom one has no relations but which are potentially conflictual because avoided out of fear);
4. Blaming "society" or its equivalents: crisis, unemployment, "the system".

Epilogue

Today Lucie's parents say she is better: "She is quieter, she looks better and she does not smoke any more." Mrs Costuedo is pleased and explains: "Lucie no longer mixes with the people she did before." It is interesting to note that there is no mention of the work of the seer. Lucie's cure is attributed uniquely to the fact that she no longer associates with the Other, who was responsible for the evil. On the other hand there is a reference to Lucie's “looking bad” and violence which were regarded as symptoms of her condition when she was supposed to be associating with "Travellers". This "looking bad", in the eyes of her parents, was a characteristic of Lucie when she was mixing with people who are judged precisely by their general appearance. It seems therefore that Lucie's illness is cured, for the moment. Family harmony has been partially restored. Mr Costuedo has found work again and is not so tense. He is less inclined to hit Lucie and she herself no longer complains of earache. If she suffers from it occasionally, she says it is because she has a cold. She seems pleased too that relations with her mother have been restored [23]. The new harmony is no doubt fragile. It will last until there is another rupture of relationships. Then the illness will reappear, in one form or another, as another signal of family disorder in which each will once more use illness-language to express the pain he or she experiences in the circumstances of daily life. The analysis of this material brings out the importance of family relationships in the designation and interpretation of illness on the one hand and in the recourse to therapy on the other. The role of these relationships is so important that the category of "illness", as it is constructed by those concerned, includes elements which lie beyond the scope of scientific medicine but can be decisive in determining where people go for help.

It might be expected, especially in a situation where a variety of medical resources are available, that it is people's perception of the effectiveness of a particular therapy that determines their choice. We would then have to consider the ideological basis of an individual's preference for what is called alternative medicine and ask why he should choose one type of therapy rather than another. We have seen in the case of Lucie's illness that she paradoxically

[23] It is true that the new closeness between mother and daughter may have had something to do with the presence of an observer, me, but this is not the place to enlarge on this.

preferred to seek help from a practitioner in whom she had less confidence. It was in fact precisely her lack of confidence that determined her choice. Something more than concern for bodily health was clearly involved here, and in different cases there may be other motives behind the choice of one healing institution rather than another.

At any rate it seems clear that potential effectiveness, which on the surface would seem to be the determining factor in the choice of therapy, by no means always explains sick people's behaviour. Their choice of therapy depends on their interpretation of their illness and it may even be a determining factor in the illness itself. Both illness and cure, in sum, are intellectual constructions in which especially social tensions may be expressed.[24]

The africanist perspective helped in the analysis of the case of Lucie in two ways.

In the first place, it seemed to me impossible to analyse this case without adopting the same kind of distant stance that we take when dealing with African material. Ethnologists working in Africa are used to hearing expressions like “sorcerers who kill”, or “the women’s disease”, or “the great illness”; but when they are working in France and come across expressions like “the cigarette disease”, they may be tempted to ignore it since it corresponds to nothing in the biomedical nosography. Yet this category has its own meaning and its own diagnostic content. It connotes certain symptoms and refers to a particular social situation, all of which are of great interest to the ethnologist. Bringing an African perspective to bear on the study of illness in Europe means being prepared to approach with the same interest and openness that we use in dealing with the African material all the categories of illnesses forged by people, even if they do not figure in any medical dictionary.

Secondly, the history of this family can only be understood in its specific context of life in this particular village, with these family, social and interethnic relationships. In short, one must look at the material from La Ville-du-Bois as one would look at the occurrence of illness in an African village, seeking to understand how it is interpreted and dealt with by different individuals involved according to a specific social and cultural context.

2. The Models of Accusation

We have seen how different models of accusation emerge from the way the

[24] It may be noted that unsociable behaviour like Lucie's refusal to answer when spoken to, and her slamming of doors, is elevated to the status of a *symptom* when it is felt to be in some way pathological.

various members of the Costuedo family see Lucie's "illness". I now proceed to examine these models in the light of data from other families which I also followed in La Ville-du-Bois.

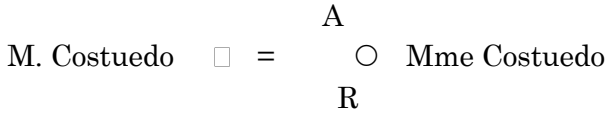
1. Self-accusation

This model can take two forms:

a) An individual may hold himself or herself responsible for the appearance or aggravation of illness. This is the punishment model: "It is my fault." "I was coughing a lot, but I did not bother about it; I have been negligent." "I smoke too much, but you know how it is, I have no will-power." This model, as noted by M. Tourolle (1990, 9), is reinforced by official slogans like, "Your health depends on you as well." It emerges clearly in the interviews conducted by Herzlich and Pierret (1984), and it is the favourite interpretation of accidents of various kinds which, as M. Augé observed, tend to be attributed to negligence. The event is then linked with the notion of the observance of codes of conduct, like alertness and self-discipline, and such an interpretation has clear political and social advantages: there must be something, or someone, one can hold responsible, there must always be a culprit to blame.

This model of "illness as punishment" need not have anything to do with religion, but it is often found in the context of religious beliefs and called "divine chastisement"[25]. We find this model in the case of Mme Dubost, a widow of eighty-nine, who complains to the children and grandchildren who care for her that her illness has been sent by God as a punishment for her failure to have sufficient sex with her husband while he was alive. It is an explanation which causes great embarrassment to her pious and chaste family.

b) An individual may consider himself or herself responsible for the appearance or aggravation of a near relative's illness. Such was the case of Mrs Costuedo when she considered that she was partly responsible for her husband's "bad nerves".



[25] Cf. Herzlich and Pierret (1984) who speak of God as "first cause" (p.139). This terminology seems to me unsatisfactory in this context, for if it is a question of chastisement the real "first cause" is the fault conceived of as the origin of the chastisement.

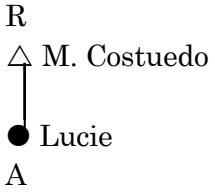
■ : sick person
A : accuser
R : person judged responsible by the accuser

2. Blaming a near neighbour (relative)

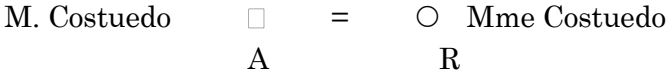
Here again one may distinguish two types.

a) Ego (the accuser) blames a near neighbour (relative, neighbour, colleague) for his, Ego's, illness.

Example 1. Lucie accuses her father of being responsible for her "earache".



Example 2. Mr Costuedo blames his wife for his "bad nerves", since she prevents him from going back home "where things would go better".

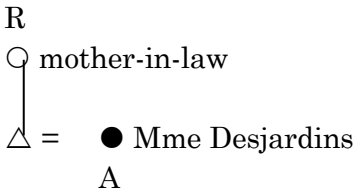


Example 3. Mme Desjardins, an assistant child welfare officer, a practising Catholic, says she has cancer because her mother-in-law is directing *"negative ions*" at her in order to make her weak.[26] Her mother-in-law, she says, was

[26] It may be noted here that, as a point of methodology, I never directly asked any of the persons involved whether or not they blamed anyone for their illness. I always kept my questions to a minimum and avoided anything that might suggest that I was expecting a particular answer. I preferred to put neutral questions like, "Why are you sick?" I may also say that the most interesting bits of information, as far as my research was concerned, were picked up incidentally, outside the framework of a formal interview. So, for example, the accusation made by Mme Desjardins against her mother-in-law cropped up when we were sitting on a sofa in her sitting-room looking through her family album.

against the marriage from the start and hates her. "She cannot bear me. I have now been married to her son for eight years, and throughout that time she has been trying to get us to divorce. She cannot forgive me for depriving her of her darling son. She is negative. You sense it in her voice and in her eyes. When she talks to her son, she has a fine singing kind of voice, but when she speaks to me she rasps like a saw. You feel these things. When someone stares at you and you feel bad, it means that they want to eat you for dinner...There are negative people like that. With healers it is different, they always send out positive ions."

Mme Desjardins refuses the treatment recommended by the doctors. She is especially afraid of the destructive effects of chemotherapy. She prefers to go to a "healer" who practises magnetism and who, she believes, radiates "positive ions" which can neutralize the "negative ions" issuing from her mother-in-law.



b) Ego (the accuser) considers a near relative or neighbour responsible for his illness, which is felt as a punishment. The formulator of the accusation is a third party. Such was the case of Mme Thévenot, a nurse, daughter of a market-gardener father and a Polish immigrant mother. She is Catholic, but her religious convictions have been shaken by her husband's illness. He is now under dialysis, and she blames him for not having taken seriously the warning she gave him several years before after seeing his blood-analysis. In her view, he under-estimated her professional competence. "I realized as early as 1982 that he had problems in that area. He had had his blood analyzed because Bourdin was checking him for high blood-pressure. I realized that there was something wrong, but Bourdin noticed nothing. I told Christian but, fool that he is, he refused to listen. I told him, 'If you have kidney trouble later on, don't go complaining!' But he did not think I was qualified to say such things and told me to look after my own business - just because I only have a nursing diploma. Well, he asked for it. His condition was only recognized in 1984, and by then the damage had been done. So it all has to be purified. It is painful at the beginning."

The hierarchical relationship between the Thévenot's has been inverted since the appearance of the husband's illness. The language of Mme Thévenot, including the above quotation, is metaphorical. "It all has to be purified" seems to include her relationship with her husband, formerly "sullied" because of his

lack of respect for her. No doubt she recognizes the physical nature of her husband's condition, but at the same time she blames him for allowing it to get worse.

M.Thévenot □ = ○ Mme Thévenot
R A

Accusing a close acquaintance of responsibility for illness, whether family member or near neighbour, is always an expression of a conflictual relationship. No doubt the idiom in which it is expressed varies. Mme Desjardins' explanation in terms of her mother-in-law's "negative ions" belongs to the sphere of the magico-religious, and there are also echoes of the common witchcraft-talk of "devouring" an enemy. When Lucie blames her father for her earache, on the contrary, there is no appeal to anything magical or religious.

In spite of these differences, as I said above I propose to treat as phenomena of the same basic kind both "magical" and "rational" explanations of illness. My interest for the moment is simply in the use made of illness by a subject in order to accuse someone close to him or her, and in the fact that his or her interpretation of illness expresses the social relations with his or her entourage.

3. Blaming a Distant Other (stranger).

In a further accusation procedure, I, ego, judge someone outside my family, or network of close connections or cultural group, responsible for:
a) My own illness;
b) The illness of a close friend or relative.

I understand by the "culturally other" one who has a different system of values from mine and a different style of life: social, economic, symbolic. The "other" in this sense may be envisaged either as an individual or as a group.

Example 1. The perception of the Other as the active agent of evil, at different levels, is common in La Ville-du-Bois. So an elderly market-gardener blamed the Other for the aggravation of his physical condition. The Other here stands for anyone not belonging to the original, native population. M. Boulanger blamed "the newcomers", with their selfishness and lack of sense of solidarity, when no one offered him their place in the waiting room of the Medical Centre, although he told the other patients that he had to see the doctor urgently because of an inflammation of the arteries in the foot which was giving him

great pain. "I had to wait for more than two hours, and of course my condition got worse," says M. Boulanger of the gangrene in his foot. The negative behaviour of the "newcomers" is cited as an aggravating factor of his illness.

The Other is evidently conceived of as the one by whom evil arrives and gets worse. His "otherness" is objectified according to the situation of the subject. For the market-gardener, the Other is "the newcomer"; for the Portuguese, he is "the Traveller".

Example 2. Mr and Mrs Costuedo blame "the Travellers" for their daughter's illness. It is dangerous to associate with them, and the Costuedo's suspect them of having provided Lucie with drugs.

The accusations brought against the "Travellers" by the Portuguese Costuedo's, and against the "newcomers" by the native M. Boulanger, are connected with the wider relationships between the different socio-cultural groups present in the commune, and are based on the representation of alien groups as potential aggressors. The accusation brought by Ego against the strange "Other", the one outside the patient's family or social group, depends on the position of each in the social complex and on the mutual relations of the groups to which each belongs. The accusation process follows a logic of suspicion according to which "the further a person is removed from me socially, the more likely he is to produce or to bring me harm". The "others" for the old inhabitants of La Ville-du-Bois are the "newcomers", for the French they are the Portuguese, while for the non-travellers they are the Travellers: and, even more, the Travellers who do not live there but come from the neighbouring commune of Marcoussis. The patterns of accusation are therefore connected with the demographic and sociological configuration of the commune and in particular with the tensions between the different groups. These tensions are the key to the schemes of accusation-legitimation produced by the subjects: the groups accused are those regarded as the most alien and as having the least right to reside in La Ville-du-Bois. In short, the inhabitants of the commune develop a theory of responsibility for illness which corresponds to their perception of legitimacy of residence: the less legitimate the residence, the greater the responsibility for illness.[27]

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[27] Just as illness can be blamed on the cultural Other, so health may be seen as an incidental benefit of security, of a life, that is, safe from the aggression of the strange Other. I have referred to the underground passage beneath Route Nationale 20 which the inhabitants refuse to use. This behaviour can be compared with people's shopping habits. People's fear of aggression, theft, assault and death partly determines where they go to do their shopping. This climate of anxiety, which individuals also project onto the wider national scene and which is kept up by the media, also gives rise to protective behaviour: people seek to defend their life, their house, their property, against the depredations of the Other by installing alarm systems. In some respects these systems resemble the fetishes and magical objects of various kinds found in other societies, intended to prevent access to certain places: they have a ritual value. The activation of

From the Familiar Other to the Strange Other

In terms of responsibility for evil, it is a temptation to think that the distinction is between the collective responsibility of the Foreign Other on the one hand, and the personal responsibility of the Familiar Other on the other. In the former case, it is the group as such that is accused, whereas in the latter case it is only an individual. This distinction however is of doubtful utility, since the Family Other - father with regard to son, mother-in-law with regard to daughter-in-law - is also part of a wider group of relationships: the parental generation in opposition to that of the children, the in-laws in opposition to blood relatives.[28]

It is true that the accusations we are considering here are not made the object of public pronouncements, such as J. Favret-Saada found in cases of witchcraft (1977, 1985); nor are there the public denunciations described by L. Boltanski[29]. Nevertheless there is a sense in which the accusation is published, and we may consider the conditions of such publication.

a) It may be granted that the accusation generally remains secret and is only divulged on some suitable occasion, such as a visit from an anthropologist. It is then communicated as a confidential piece of information, as if it were something which the subject thinks but does not like to speak of. This is especially the case when the accused is a Family Other.

b) One may also agree that the accusation is communicated to a limited circle of people. It is only to his intimates that Ego confides his impressions and interpretations and his general view of people and things. Once made however, the accusation circulates in the form of a rumour.

The group of "intimates" is the group with which Ego identifies himself, and when the accusation is directed against a Foreign Other the two groups concerned are ranged in opposition. It was to other Portuguese - relatives, friends, neighbours - that Mr and Mrs Costuedo voiced their suspicions that

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the alarm constitutes a demand for the punishment of an aggressor. No doubt the secret number, or code, which activates the alarm system is not in itself sufficient to prevent theft, but it is a kind of magical gesture calling for the punishment of the transgressor. One cannot say that a burglar alarm is simply the equivalent of a fetish, for it is certainly not normally an object of religious veneration. Nevertheless it resembles a fetish in that it is regarded as an effective deterrent. It does not act, but its very presence serves to discourage.

[28] In this connection, the image of the mother-in-law, on either side, is very interesting, and might well be made the object of an anthropological study.

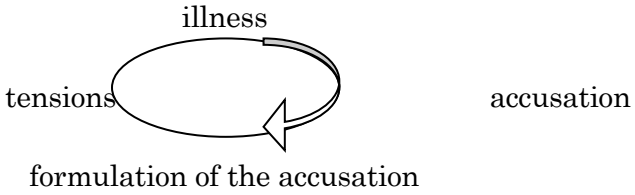
[29] "Denunciation...in fact supposes reference to a guilty or responsible party who may be represented by an image. There is a system of casuistry here which has its own logic. Even abstractions may be identified and proposed for public revenge. One may think of the use of the term 'capitalist' in a meeting of trades unionists called to protest against

the "Travellers" had provided the drugs which were responsible for their daughter's condition; M. Boulanger's complaints about the selfishness of the "newcomers" which had aggravated his diseased foot were addressed to other old market-garden families. [30]

Nevertheless, whether the accusations remain private or are publicly aired, and whether they are made against the Familiar Other or the Strange Other, they have important social consequences.

a) The accusations increase the tensions in the community. The hostility between the different groups is exacerbated: natives/newcomers, French/Portuguese, residents/"Travellers", etc. There is a reciprocal movement in which the accusations increase the tensions of which they are the expression.

In the same way, accusations of responsibility for illness increase tensions between relatives. "That is also why I can't stand him," says Lucie, when she blames her father's slaps for destroying her hearing.



b) The accusations also have an impact at the level of the wider social life of the community. They confirm the accusers in their avoidance-behaviour towards the accused. After his experience in the Waiting Room of the Medical Centre, M. Boulanger no longer takes part in the meetings of Elderly Citizens, and Mr Costuedo refuses to allow his daughter to frequent the Youth Centre where she might meet the "villains and Romanies".

c) Finally these accusations have an influence on the way people seek therapy. Their therapeutic behaviour can be regarded as a kind of strategy in the sense that it is intended to manipulate or even destroy the evil for which the particular Other is held responsible. One may think in this connection, not

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redundancies." (1984 p.3)

[30] This type of accusation is not very different from talk about transmissible diseases like AIDS, blamed today on Blacks, as the plague was blamed on Jews in the Middle Ages. These attributions also involve two groups in tension, one accusing and the other accused, though in these cases the accused one is regarded as actually bearing the illness in his or her own body.

only of Lucie's refusal to follow the treatment prescribed for her otitis, but also of her confinement by her father, or her desire to escape from home. The key to these various aspects of the situation is the symbolism of "inside/outside". Confinement and flight are both conceived of in terms of an escape from a particular place regarded as unhealthy, the Youth Centre in the one case and the home in the other.

These different styles of accusation have to be analyzed, it seems to me, according to the relations subsisting between the sick person, the accuser and the person accused. It is not only a question of finding out the likely consequences of these interpretations, as I have outlined them in a) above, but also of perceiving their possible impact on the kind of therapy which is sought, according to whether the accusation issues from the sick person himself or from a member of his entourage. The relative positions occupied by the various players are very different in the cases we have considered, and it is in terms of these positions that we have to enquire about the power-relationships between the groups and individuals involved in the accusation-drama.

4. Blaming "Society"

The term "Society" is used here to denote a variety of models which, while not always referring to the same reality, have the common characteristic that they all put the blame on some aspect of contemporary Western society: political, social, economic, ideological, ecological. The term "blame", as distinct from simply "cause", is appropriate in this context because Society is treated as a kind of personal subject and made the object of a judicial process, as we shall see later.

In the situations I have here in mind, Ego holds "Society" (or its equivalents like "the System", "the Modern World", "Society today") responsible for his evil or that of someone near to him. So we find Mrs Costuedo blaming "France" and its various problems ("unemployment and everything") for her husband's "bad nerves".

This model of abstract responsibility appears very clearly in the interviews conducted by Herzlich and Pierret, where something called the "style of life" is treated as a comprehensive cause of illness. Herzlich had already observed in 1969 that "the individual *interprets* illness as a kind of thing which is imposed on him by the conditions of life" (p. 176). "As far as the individual is concerned, interpreting illness means attributing it to aggression on the part of society" (p. 177). She later confirmed, with Pierret, that "the cause of illness today is sought in the notion of 'the modern style of life', and in particular of 'the urban style of life'." "If it is the style of life which gives rise to illness," the same authors continue, "illness in turn can be given objective

meaning: it incarnates at the level of the body our negative relationship with what we call the social reality." "Illness has become for the individual a social condition, a new structuring of the relationship to what we call society." "Illness is a metaphor for a society which attacks the individual even in his body. The sick man is both the victim and the evidence of the evil of society" (1984, pp. 143, 145, 292, 293).

I was struck by how often the expression "the life one leads" cropped up in the conversations I had in La Ville-du-Bois when I was thinking about this model. Through the medium of illness, it was, paradoxically, life which gave birth to death. It is "the life we live" which is responsible for illness and death. Life brings death. Behind the paradox however one can see that it is not life itself but "society" which is cited as responsible for death.

Social Causality in Scientific Discourse

It should be observed that this habit of attributing causal efficacy to "society" is not confined to popular discourse. We find it also among health professionals. They are of course aware of the organic and functional nature of illness, but they are quite willing to assign to it a social cause. In particular the declarations of the devotees of preventive medicine correspond perfectly to the fourth "social" model we are here considering. This is especially true of the type of preventive medicine which blames society for epidemics. Campaigners who blame society and advocate what they call "the policy of prevention"[31] are to be distinguished from those other advocates of preventive medicine who blame the individual for indulging in unhealthy habits like smoking and drinking. Within the former category come those who speak of the degradation of the life-environment in terms of such developments as urbanization, industrialization,[32] social inequalities, poor housing and conditions of work, lack of information, unadapted structures, the priority given in our society to "economic considerations". In this approach, as in that of our "Urbisylvans" who blame "Society" for their troubles, society is transformed into a kind of subject engaged in the ruthless persecution of individuals, and in particular of under-privileged individuals. "Everything suggests," write the authors of the report just referred to, "that, as society condemns some people to death, so it chooses its victims for illness" (1982, p. 32).

The specific character of our fourth model, which makes it radically different from the preceding three, is that its attribution of causes is more directly political. No doubt all accusation models involve the notion of

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[31] I refer in particular to the authors of an official report to the Ministry of Health in 1982 entitled, "Proposals for a Policy of Prevention", in *La Documentation Française*.

[32] This kind of talk recalls that of the nineteenth-century health enthusiasts mentioned by Herzlich (1969), who regarded disease as the consequence of social

persecution: in all of them the sick person is seen as a victim, either by himself or by his entourage. Victimization is the converse of accusation. The kind of causality envisaged however differs according as the responsible agent is considered to be oneself, an Other or society[33]. When Herzlich writes that illness "functions as a focus of meaning and expresses our relation with society" (1984b: 23), she is articulating an interpretation of illness which makes society responsible, an interpretation, that is, which corresponds to what I have presented here as the fourth model. We have however seen that the relation to the Other which underlies the interpretation of illness cannot be reduced simply to the relation between the individual and his society.

One may underline here the value of our methodology as a heuristic device. It is probably true that it is not easy to identify the responsible "Other" in the context of a formal interview in which people are invited to speak of a particular illness. In the first place, communicating such an accusation demands a fairly high degree of intimacy, especially when the suspect is a member of the family; but, even more importantly, it supposes a clarity of thought and reflection which cannot always be looked for in an interview in which people are rather abruptly expected to have a clear idea of how they interpret a particular illness.

Reflection on illness is too abstract an exercise, too remote from the actual, lived experience of illness, to permit a comprehensive response to the researcher's question. However explicit may be the responses of subjects in Western societies to sociological questionnaires, we believe that they leave largely untouched the whole field of social causality.

The material I collected in La Ville-du-Bois leads me to believe that, alongside the model of a healthy individual opposed to a sick society (Herzlich 1984a, 1984b, Herzlich & Pierret 1984), we must place, or perhaps superimpose, the model of a healthy individual opposed to an individual conceived of as unhealthy, or at least as involved in a relationship perceived as unhealthy. The tensions which underlie these interpretations of illness are connected with the way people feel about themselves, their body and the Other, the latter including both the one within the family group and the one outside it, the Stranger.

It remains to enquire about the logic which determines which of the available accusation-models is adopted in a particular case. What is it that leads people in some cases to pin the blame for illness on "society", in the form of the city perhaps or of pollution, rather than on an individual or the group? Is

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conditions in the industrial world.

[33] It is possible for models 3 and 4 to be combined. The accusation of an Unknown Other may be accompanied by blaming society and its development. When M. Boulanger condemns the "selfishness" of the "newcomers", he is blaming "today's society" for the disappearance of values like solidarity and mutual aid.

the preference for what one may call a social accusation connected with specific cultural factors, or is it reserved for special kinds of illness?

The question is difficult, for the illnesses in question may not figure in any medical textbook. Even if they do, their description may by no means correspond to the actual situation, as we saw in the case of Lucie's "ear trouble".

As regards our fourth model, it seems possible to formulate the hypothesis that it is essentially prevalent among French people and rarely found among "foreigners". In particular it seems that members of other cultures only adopt this model when they have already attained a level of acculturation which enables them to look at society with a critical eye. The example of the Costuedo's is instructive from this point of view. Mr Costuedo, who has remained very attached to Portugal, blames his wife's behaviour for the state of his nerves. Mrs Costuedo however has more contacts with French society. She speaks better French than her husband and wants to remain in France. She also has an urban background. She is therefore more able to explain her husband's condition in terms of the two models of self-accusation and "society". It may therefore be that the society-accusation model becomes more prevalent when the subject either belongs to, or is becoming integrated in, French society. One might advance the hypothesis that the same illness is interpreted more or less in terms of society in proportion to the degree of Westernization of the subjects concerned.

To give more substance to this reflection, it may be useful to bring into the picture the findings from radically different, lineage societies.

IX. AN AFRICANIST PERSPECTIVE

We might be inclined to think that a vast distance separates Western societies and the lineage societies of Africa. Yet when we compare the models of accusation we found in analyzing concepts of illness in Western societies, of which La Ville-du-Bois is representative, with those found in the lineage societies of Africa, it is clear that, while there are differences between the two which deserve investigation, there are also remarkable similarities.

As will become clear, my effort here is to examine and compare two forms of what it is customary to call social etiology, or causality. This does not mean that social etiology is the only model of causality found in the cognitive systems of African societies. In Africa as in the West, various explanatory systems are combined. There are, for example, explanations based on natural causality, connected with notions of contagion, contamination or heredity, which are independent of the social order. Natural explanations can displace explanations in terms of social disorder (cf. Fainzang 1984, 1986). It is however precisely because in ethnological literature social explanations of illness are commonly presented as something peculiar to African societies that I have chosen to focus my reflections on these explanations in order to show the important place they occupy in Western societies also.

Some of the models presented above are found in both African and Western types of society, while others seem to be characteristic of Western society. In particular, the study of lineage societies shows that people there explain the onset of illness overwhelmingly in terms of the models of self-accusation and of accusation of the Other.

The model of self-accusation in lineage societies is exemplified in diviner-consultations. The sick person himself is living proof of misconduct somewhere, and the task of the diviner is to conduct a diagnosis to find out where. He may either declare the cause of the illness (cf. Fainzang 1986, on the Bisa of Burkina Faso), or bring the sick person himself to confess to "diabolical practices" which are conceived of as responsible for the evil[34], according to a pattern of causality which anthropological literature likes to describe as "endogenous", or self-generating.

One also finds, in both Western and lineage societies, the model of Other-accusation, although this takes a different form in each. In lineage societies, and particularly in those marked by a morbid fear of persecution, illness is regarded as the work of an Other. Accusations of witchcraft are the typical expression of this interpretation. Writers sometimes speak in this case of "exogenous", or external, causality. The classic example is the work of

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[34] cf. Augé 1975 on the therapeutic practices of Bregbo in the Ivory Coast, in which the prophets bring the responsibility for illness home to the sick person himself.

Evans-Pritchard on the Azande (Evans-Pritchard 1968).

At the same time, analysis of my Western material has helped me to perceive two models, or two images, of the Other: there is the Family Other, with whom one is in a conflictual relationship, and the Foreign Other, with whom one has either a conflictual relationship or a relationship of avoidance corresponding to one's negative image.

The Areas of Accusation

In the case of the Family Other, one may compare the process to a witchcraft accusation since the accused necessarily belongs to the network of close relatives. In many African societies, only those belonging to the victim's family are suspected of witchcraft. In the case of the Bisa, the circle of suspects is restricted to those living in the same compound. The different rules of witchcraft accusation are summarized in a theory which Sindzingre has formulated thus: "suspects are classified in terms of age and of their connection with a particular lineage or neighbourhood." "Mutual personal hostility cannot be assigned at random," she adds, echoing what Augé has said about the variations of witchcraft theories according to societies (1974, p. 54).

This phenomenon of accusing the Near Other of witchcraft cannot be restricted to African lineage societies. The work of Favret-Saada (1977) shows that Mayenne concepts of witchcraft too envisage the sorcerer as necessarily belonging to the victim's familiar circle, and Bougerol has written similarly of the Antilles that "before he can inflict harm, the aggressor must have a motive, and this supposes a minimum of contact between himself and the victim. The sorcerer is therefore to be sought in the social or family or neighbourhood circle" (1977).

In La Ville-du-Bois we are not dealing with witchcraft as such, but with accusations levelled against the Other considered responsible for the onset or aggravation of illness. Here too there has to be a certain proximity to Ego in order to make the connection between the negative action of the Other and Ego's illness. Such was the case with Mr Costuedo and his daughter, and with Mme Desjardins and her mother-in-law.

It may be that the logic of witchcraft-accusations can be subsumed under the more general category of "Accusations Directed Against the Other". Witchcraft may be just one species of a wider genus.

In the case of the Foreign Other, on the contrary, the accused must be sufficiently different and distant from the sick person concerned to warrant accusation, since it is precisely his difference, his otherness, which makes him a harmful agent. Such was the case of the "newcomers"in La Ville-du-Bois with regard to the natives, of the Portuguese with regard to the French, of the

"Travellers" with regard to the residents.

The rule governing the list of suspects, to adopt the terminology of Sindzingre, is therefore here reversed. It is their otherness rather than their proximity which makes them suspect. Even here however, as has been seen above, suspicion is not random. There are prime suspects. The accused is most often the one conceived of as the strangest, not only in terms of the victim, but also in terms of the commune's space.

Furthermore, contrary to what has been noticed in accusations of witchcraft, accusations against the Foreign Other in the cases I have been considering are not connected with the power-relations between individuals. One of the reasons for this may be that, as we have seen, the accusations in La Ville-du-Bois, unlike witchcraft-accusations in Africa, are not made openly, or at least not in public [35]. Nevertheless, even though the accusations are not subject to power-relations, they must still be intellectually credible. If they are to seem probable and "natural", they must be in conformity with the social representations of the Other. In the case of La Ville-du-Bois, this means that the accusation must be connected with the idea that the group of the Other has less right to be living in the commune's space than oneself.

The fact that accusations of responsibility for illness are more discreet in a community like that of La Ville-du-Bois than public denunciations of witchcraft in Africa, may be partly due to the fact that illness in a Western society does not have the same social function as it is generally considered to have in African societies. Blaming the culturally Other for illness in La Ville-du-Bois does not disturb what one may call the social fabric of the group, since the accusation is not made in public and anyway the alleged perpetrator is unaware of it. As we have seen, the effect of the accusation is rather to legitimize avoidance and separation between the groups concerned and to increase tensions. The social function of illness here is therefore to provide a justification for people's prejudices and for the exclusion of certain socio-cultural groups. These interpretative models have therefore a decisive role in reinforcing and legitimizing the tensions between groups and their mutual avoidance. They strengthen already-existing social divisions.

These reflections suggest that the fundamental difference between witchcraft accusations in Africa and illness-interpretations in Western society is to be sought, not so much in terms of their "magical" or "rational" character respectively, as in the relative positions of the protagonists. It is these positions which determine both the meaning and the function of accusations.

Finally what differentiates the two models of the Other is not simply the kinds of accusation of which they are the object. One finds among people like the Bisa accusations of magical behaviour which, although distinct from

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[35] Although some witchcraft-accusations in African societies may be made in secret. I owe this observation to S. van der Geest.

witchcraft, also supposes a relation of hostility or rivalry between aggressor and victim. What one must however also consider is the kind of responsibility attributed in the two types of society to the alleged author of the misfortune.

An examination of the different models proposed here clearly implies a distinction between responsibility and intention. When someone in a place like La Ville-du-Bois says that X is the cause of a certain misfortune, he does not know whether or not the action was deliberate. Zempléni wrote that in the lineage societies of Africa however illness is perceived "as the result of the deliberate action or wish of the Other" (1982: 8). Accusation of the Foreign Other in a community like that of La Ville-du-Bois does not imply a persecuting intention. The culturally Other, the Stranger, may not intend to do evil, but he carries the evil within him. It is in his nature, and his very presence, along with his behaviour and his style of life, of themselves bring evil. Certain individuals or groups are intrinsically bad, they radiate evil as it were in spite of themselves. In this situation the cause of the illness is not so much the harmful action of an exterior agent as his very being.

Subversive and Reproductive Causality

Finally, one does not find in lineage societies the typical Western tendency to blame "Society" for illness and misfortune[36]. This is not simply a matter of the "stage of development" of traditional societies. Some people would say that those in traditional situations have no reason to blame the evolution of "society" for their troubles, since they have remained untouched by "modernity", industrialization and urbanization. It is true that "difficult working conditions", whose denunciation is one of the favourite forms of the fourth model of accusation in the West, are by no means the exclusive property of the West. It would however be difficult to find an individual in a lineage society complaining about the rhythm of work imposed by the socio-economic system which regulates the organization of production in his society. Nor does one hear complaints about work-accidents which may result from this organization. The "infernal" rhythm of work imposed on workers, and the inadequate security, may be invoked in the West as the source of misfortunes; but one never hears such complaints among the members of a lineage society, even when, for example, a man accidentally strikes his neighbour's foot with his hoe in the kind of collision which can occur when people are working side by side in the field. Nor would one find a woman who suffers from backache through having to lift heavy loads of firewood complaining about the "system" which is responsible for imposing such working conditions on women. It is not

[36] Though the accusation of Society (of the State, the System, etc.) has to be socially relevant (as Evans-Pritchard showed concerning diagnosis in Africa) to be made by people.

simply the material or environmental conditions of work which give rise to such interpretations of illness: a key factor is the existence of a critical attitude of the individual towards society.

The readiness with which one of the above-mentioned models of illness-interpretation is adopted is a clear index of the relation between the individual and society in different social, historical and cultural contexts. Models 1 (self-accusation) and 2 (accusation of a Family Other), which seek to explain illness in terms of the behaviour of the sick person or of someone close to him, predominate in lineage societies; whereas Model 4 (blaming "society") explains illness by referring to the nature of society. In lineage societies, the tendency to blame individuals for misfortune aims at ensuring continuing obedience to society's rules; whereas casting the blame on "Society" in the West is an expression of the interpreter's desire to change it.

Not only is society not blamed in lineage-type organizations; the interpretations of illness serve on the contrary to reinforce society's functioning and cohesion. Where the Westerner may bewail the evils of society and dream of living under a different system, either as it was in the past or as it could be in the future, the members of lineage societies want nothing better than to go on living in the same society which their ancestors have bequeathed to them. Whereas Westerners aim at a better society, however variously and even contradictorily envisaged, people in a lineage system aspire only to help their ancestral society to remain as it always has been.

The situation may be expressed thus: while the type of social causality reflected in Model 4, peculiar to the West, may be either future-orientated, in the sense of building a better future, or past-orientated, in the sense of restoring the pre-industrial, pre-urbanization or the pre-immigration situation, the social interpretations offered by lineage societies are uniquely past-orientated. By blaming social disturbances for disorders, they imply that order is to be restored by taking the past as model. [37] It is true that certain social interpretations of events in lineage societies may imply resistance to the unquestioning reproduction of the past envisaged by the system of social etiology (cf. Fainzang 1986), but even these never call into question the basic values of the society. However socially discordant and contentious some interpretations may appear, they are to be understood as a kind of personal strategy rather than as a condemnation of the "system" or of the social order as such.

The witchcraft-accusations analyzed by Augé certainly tend to increase social divisions, between the generations for example, but they are not

[37] On the attitudes of different societies towards their past, see Duval 1986. For him, it is the attitude to the past which distinguishes state totalitarian systems from stateless totalitarian systems, which he places in the category of "elementary totalitarianism".

subversive of the whole social order (1975, 97). It can happen that the interpretation and treatment of illness plays a decisive role in the establishment of a new order. Zempléni (1982, 15-16) has shown how the Mourides of Senegal used new interpretations of sickness to further their expansionist policies. In this case however the new order was imposed from without and was in no way the result of internal criticism of society by the Wolof themselves.

Western social etiology is in fact an expression of confrontational politics, although it may at the same time also be reactionary in the sense that it condemns modern life. One may say the same thing about the use of model 3 in Western society, for this model queries the modern tendency to intensify the co-existence of heterogeneous socio-cultural categories.

One may cite in support of these observations the work of Hours (1986) who found in the Cameroon that it was above all in the urban milieu of Douala that one heard criticisms of the State (the fundamental symbol of "society") from people dissatisfied with the public health services (p.154). It looks as if the State only appears as persecutor, and sick people only appear as its victims, to those who, while retaining the traditional concept of persecution as the cause of misfortune, are at some distance from the traditional interpretations of illness. This applies especially to sick people themselves, who are brought into immediate contact with social and political realities in a country like the Cameroons, in which, says Hours (p. 15), the State is omni-present to people's consciousness (p. 151).

These remarks suggest that illness-talk is an expression of the relationship between people and their society, not only at the socio-political level, as Herzlich & Pierret have shown[38], but also at the philosophical level.

It may be that the absence of Model 4 in lineage societies reflects a different, uncritical mode of thinking, a mode characteristic of these societies and attributed by Jack Goody to the absence of a written tradition (1979, 96). In fact it raises the wider question of belief and consensus. When Goody opposes an oral to a written tradition, he is in fact repeating, and transposing, Lucien Febvre's distinction between the Europe of the Renaissance, in which written materials were accessible only to the few, and there was little scope for critical thinking, and the later Europe of the printing-press. In Febvre's view, it was the invention of printing which made possible the diffusion of different people's ideas and gave rise to the emergence of a critical tradition.[39]

We may say in summary that what distinguishes the two types of society

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[38] They write: "Illness, health and the responsibility of what has been called 'the Welfare State as Provider' in this area are leading people to query the very form of modern society and its future viability" (1984: 295).

[39] Febvre attributes the decline of religion to the appearance of new tools and materials, above all the printing-press, which allowed texts to be put together, transmitted, interpreted and commented on (1962: 418).

and their interpretations of illness is not simply the historical relation between the individual and Society, but also the relation of the Society itself to its own tradition. When we look closely into the matter, it appears that the real difference between the two systems of interpretation is not, as one might at first imagine, between the *magical* and the *rational* mode of thought. When we think of the different models of accusation used in the interpretation of illness, we can see that the differences have little to do with either scientific development in the society concerned or the particular environment and the material conditions of life out of which they arise. Different social interpretations of illness are to be understood as deriving on the one hand from the specific historical and political characteristics of the societies in question, and on the other hand from the philosophical conception which the society has of itself and its history.

Only One Misfortune Among Others

There is a tendency for Africanists to say that the specific character of African theories about the causes of sickness is that these causes can also be applied to a broader spectrum of misfortunes. It is however by no means certain that it is only African societies, or even only traditional societies in general, which apply the same explanatory formulae both to illness and to other kinds of misfortune. In the West also illness is treated as only one misfortune among others, and all are susceptible of the same kinds of explanation.

Case-studies show that the "Near Other" may be held responsible not only for illness but also for the loss of a job, for failure in love, for exclusion of some kind, for a precarious economic situation, for bankruptcy. Similarly the "Culturally Other" is blamed for a variety of ills: crime, unemployment, drugs, noise, dirt, insecurity. Finally "society" is considered responsible for the loss of personal contact, for poor communication between people, for the degradation of nature and the countryside, for economic crises, not to mention all the so-called modern illnesses. We may take as an example M. Lesueur, a seed merchant, originally from Normandy, who has been in La Ville-du-Bois for twenty-five years. He blames "modern life" for the collapse of his business. "People are too busy. They do not want to waste time in the old village centre looking for somewhere to park, so they go to shop for food further away. The consequence is that there is no more loyalty, no more contacts, and that can only mean ruin for a business like mine."

A second example may be drawn from the utterances of the devotees of preventive medicine referred to above. They too tend to regard illnesses as one of the harmful aspects of "modern society". "In the field of prevention priority must therefore be given to those who are the special victims of the negative

factors in society: work, wages, freedom, housing, education."[40] In this jargon of preventive medicine, illness seems to be accorded less independent reality than cure, and good or bad health is seen as a product of the general life of the society in exactly the same way as it is regarded in the diviner-systems of Africa.

Illness then, like other human misfortunes, is a particular idiom in which disorder is expressed. The body is turned into a kind of lexicon containing a variety of expressions. One may choose one expression rather than another for a variety of reasons: there may be some symbolic correspondence between the disorder and the expression, as in the case of Lucie who, cut off from the world by her father's order, complains of earache and says that his slaps are going to end by making her deaf. If this interpretation is correct, we are in a situation similar to that described by Augé in connection with the Alladian of Ivory Coast: among them, he says, "the systematic linkage between physical symptoms and social disturbances is not a random matter but is the expression of an unconscious symbolic order" (1979, 179).

What we want to know is whether the connection between what is conceived of as illness and the interpretative accusation, whether made by the sick person himself or by someone close to him, is simply arbitrary or whether it corresponds to a symbolic order. If the latter is the case, what are the parameters for the constitution of such an order? To pursue this line of enquiry, it would be useful to accumulate a number of case-studies and to make a distinction between two types of code: a cultural code, such as the Portuguese code of a "nervous illness" which we have seen, and an individual code, connected with the subject's personal perception of the conflict underlying the attribution of responsibility. The two codes could then be combined and reconstituted according to the personal history of the subject.[41]

The analyses offered here are to be understood as an attempt to uncover the underlying similarities between different societies. I am looking for universal concepts, while respecting the particularity of each culture. My project differs therefore in the first place from that of authors who, in seeking to draw up a classification of types of social causality, make a radical difference between them, whereas we have seen that in fact both "natural" and "social" explanations are found in each type of society. It also differs however from the

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[40] *Cf. Propositions pour une politique de prévention*, p. 120. The authors list the evil effects of social inequalities: disease, death, misery, premature aging, madness, injustice, loss of dignity, solitude (cf. volume of Appendices, p. 15).

[41] This kind of codification may vary according to the particular historical and social situation. Thus Mrs Costuedo, of urban origin and partly acculturated, changes her explanation of her husband's "nervousness" from the traditional Portuguese formula of "family troubles" to an explanation in terms of the difficulties involved in living in French society.

enterprise of R. Horton (1967), who does not admit any formal difference between the magical and the scientific experience, and who seeks to show the similarity between the modes of thought of traditional Africa and the theoretical models of Western science. There is however one important difference which should not be overlooked, namely, the critical spirit which informs some Western interpretations, whether lay or scientific.

No doubt anthropology is in search of the universal, but this quest must not be allowed to obscure the specificity of the areas under investigation. Recognizing the essential unity of human kind does not mean refusing to accept that culture fashions it into different shapes. What I have tried to do is to show how the same logic of the interpretation of evil may take different directions, and that these directions are bound up with the socio-political contexts within which human thinking takes place, a thinking which is both universal and particular.

AFTERMATH

The last decade has seen a veritable flowering of anthropological studies on Western societies, and this has provoked reflection on the possibilities of such work and on the particular problems involved. I mentioned in the Introduction to this work the 1998 conference in Zeist on "Medical Anthropology at Home". Realizing that it is only recently that anthropologists have begun to take an interest in their own Western societies, the organizers of this conference wished to encourage collective reflection on the theoretical and methodological implications of medical anthropological research applied to new objects and in an area regarded as familiar to the scholar. (cf special issue of *Anthropology and Medicine,* "Medical Anthropology at Home", 1998.) The conference also provided an opportunity for discussing a number of epistemological problems involved in working as an anthropologist on familiar field.

The questions raised during the conference belong in fact to the wider context of the contemporary discussion on the methodological, epistemological and theoretical questions in general social anthropology. Anthropologists are beginning to ask questions about the relevance of their subject and about the use which is made of its findings. It is natural that matters raised about social anthropology in general are also being raised in the particular context of medical anthropology.

There is however special hesitation concerning the objects of this field of research, and this can sometimes complicate the relations between the social and the medical sciences. It was not surprising that at the Zeist conference questions were raised about the connection between medicine and anthropology, and these questions led to reflection on the obstacles to, and the conditions of collaboration between these disciplines in our societies. The problem is whether the dialogue between medicine and anthropology is really a dialogue between two distinct sciences at all, since there are some who consider anthropology as a branch of medicine, while others regard medicine as belonging to anthropology. We need to clarify what medical anthropologists are really doing, and which activities belong to medicine and which to anthropology.

At the same time, we may surely ask whether medicine is not a proper object of study for anthropology. There should be an effort, especially on the part of those who are both doctors and anthropologists, to explain that medicine is not simply a scientific activity which co-operates with anthropology in situations of illness but may be itself an object of anthropological study, especially in our Western societies. One of the claims

of medical anthropology “at home” is precisely that it can use its specific tools to analyze biomedicine. I enter willingly into this debate and would strongly affirm, as I did in my study on La-Ville-du-Bois, that one must study the theory and practice of biomedicine exactly as one would study any “lay” pattern of social behaviour or “exotic” medical practice. To this end, we must learn to be astonished by what we observe through distancing ourselves from the theory and practice of biomedicine.

What this means, from the epistemological point of view, is that medical anthropology must not rely on the medical paradigm. I do not quite agree with Zimmermann (1995) when he writes, for example, that we cannot simply abandon the medical point of view if we aspire to do anything more than religious anthropology. I believe that one is perfectly justified in examining the domain of illness and medicine in terms of non-medical categories and, more specifically, of exclusively anthropological categories.

This was no doubt the position of Lock and Gordon (1988) when they proposed to study contemporary medicine as a cultural phenomenon. For this purpose they collected a number of contributions which showed the values embedded in biomedical knowledge and practice. The authors rightly observe that anthropologists have for many years simply ignored modern medicine, claiming that it evolved in a scientific atmosphere very different from the religious beliefs which are at the heart of traditional medicine. It is agreed that the task of the medical anthropologist includes trying to describe local beliefs about the causes and prevention of misfortune, methods of diagnosis, the classification and naming of diseases, healing rituals, and interpreting the beliefs surrounding illness and healing, while showing their mutual connection and their impact on other aspects of the culture. Yet, Lock and Gordon regret that certain areas have been neglected and that even the content of medical knowledge has rarely been examined, on the grounds that is based on science. In a no less pioneering work, Kirmayer Lawrence (1988) subjects to a critical examination the values behind the medical rhetoric of scientific rationality, underlying the representations associated to "mind" and "body" (in particular in the so-called psychosomatic illnesses). He shows that the opposition erected between the two terms is at the base of standard medical consultation and practice.

Anthropological research in Western culture has benefited from work carried out in “exotic” societies, by taking account of the objects studied and the problems encountered in the latter. Anthropologists have thus been able to renew the way western societies are studied and to increase their knowledge. This applies for example to the problem of AIDS, which has been the object of a number of studies both in areas traditionally of interest to the ethnologist and in Western societies. This twofold effort has made it possible to formulate new questions on the subject. The research led in “exotic”

societies have also cast light on the irrationality of conduct in Western countries and have been helpful in studies of such things as diabetes, drug- and alcohol-addiction, and the use of psychotropic medicines.

One of the central questions encountered in the anthropology of illness concerns the connection between the representations of illness and the kind of therapeutic procedures to which individuals have recourse. We need to understand the nature of the impact of the representations on the practice. Once the close connection between the two has been established, we have to try and uncover its logic. The logical link is far from being always evident, and many ethnologists today are exercised by this problem which came to the surface during a colloquium on AIDS organized in Aix-en-Provence by Jean Benoist (cf. Benoist and Desclaux 1995). In the course of his presentation, Gilles Bibeau appealed for a new assessment of the so-called rationality of human beings and of the consistency of their behaviour. He called for a study of the connection between what people know about the probable consequences of their behaviour and their actual conduct (cf. Bibeau 1995). It is clear that it is no longer fashionable for anthropologists to look for any medical logic in the way people behave when confronted with illness. In the West no less than in the developing world, the logic is more social than medical, but this social logic is not easy to articulate. The ethnologist may be bewildered at the lack of rationality in people's behaviour. He may be even more at a loss if, while he first believed that there is a link between representations and practices, he then either discovers that this link doesn't exist or, at least, is led to question the coherence of the latter in regard of the first. There is in fact often a gap between the way individuals perceive their illness and the measures they take to combat it. Not only this observation is valid for our societies (irrational behaviour is certainly not confined to people in other cultures), but it takes on a new dimension when we look at the conduct of people who are the most familiar, both professionally and culturally, to rationality and medical knowledge.

The problem of irrational behaviour has also led to reflection on the phenomenon of risk. Once they became aware of the substantial gap which exists between scientific knowledge and the popular perception of health risks, anthropologists turned their attention to how people perceive and handle risk (Calvez 1989; Douglas and Calvez 1990; Zonabend 1989). Going beyond certain ethnographic studies which restricted the consideration of risk to an analysis of cultural techniques for combating danger, the contemporary anthropological approach is to examine how risk is part of a particular social context and how this same context determines what people do to deal with it. Recent studies in both Africa and France show that risks to health can be used as resources in social life and may be consciously accepted. Risk-taking need not be irrational but may be seen as a means to

an end. Health may often be regarded as a matter of minor importance compared to the benefits to be derived from a willing acceptance of risk. One risk is balanced against another in terms of the life-values of the individual. For the most part, the individual does not so much choose a particular risk as seek to avoid another. The anthropologist has his own contribution to make in taking account of the social context within which the relative calculation of risks is carried out.

In general, recent medical anthropology has been characterized by its "critical" quality, even if it doesn't claim this label. One of the principal criticisms which has emerged concerns the idea that ill-health in an individual is often to be explained by lack of knowledge and by unadapted behaviour. As Good observed (1998), too much emphasis on popular beliefs about sickness has often led to a failure to recognize the importance of the unequal distribution of health facilities, social injustice and industrial policies, as factors in the ill-health of minority communities and of deprived peoples. There has also been insufficient attention to the responsibility of international policies for underdeveloped health care. Poor access to medical facilities may often be explained more by medical practice than by the behaviour of people themselves.

The development of medical anthropology here and elsewhere has thus helped research workers to re-assess the conceptual paradigms formulated by anthropologists and to put important questions. B. Good (1998) has not only contributed to the debate on rationality and relativism, but has also proposed to go beyond this alternative and to ask about the place and status of the notion of belief in different anthropological studies and to elucidate its connection with knowledge. He rightly condemns an anthropological trend which, in spite of the criticisms made about the medical behavioural sciences, persists for the most part in reproducing the underlying epistemological structure of the bio-sciences and drawing up comparative studies of sickness-beliefs.

At the same time, it remains important for medical anthropology to try and understand the behaviour of sick people. This is not in order to bring out their distance from medical rationality but rather to uncover the underlying symbolic logic. The analysis of health problems must certainly take into account the reality of public policies and the social conditions of people's lives, but I believe that this does not render any less indispensable reflection on people's behaviour, especially when we notice that well-informed subjects also have apparently irrational attitudes. However that may be, as Nichter notes (1989), the description of traditional beliefs and rules cannot be regarded as a sufficient explanation of people's behaviour. There must also be a description of the different circumstances in which these rules are respected or ignored. One example of the interest anthropologists can have

for the symbolic logic governing people's behaviour is the work of Lieban (1992) who studied how social symbols can contribute to sickness. He considers particularly how attachment to certain social conventions and observance of certain rules of conduct can lead to pathological conditions like anorexia. In a way, Lieban's work may be compared with the analysis offered by Parsons who showed how people can derive advantages from illness, but it poses the further question of how the symbolic benefits of certain sicknesses can influence their development.

It has of course long been recognized that in the Third World traditional and scientific medicine exist to some extent side-by-side, and this perception has now become relevant also in modern, multi-cultural Western societies. The example of La-Ville-du-Bois showed clearly enough that medical pluralism is as much a reality in Western societies as anywhere else. The questions which emerged from work in other societies (cf Benoist 1996) emerge also in studies carried out in the West. We are still faced with the question of the mechanisms underlying people's reaction to sickness and their diverse efforts to find a cure. Furthermore, modern studies bring out once more the important issue of people's cultural belongings and of the symbolic systems to which they refer. The question is: when a patient chooses one type of therapy rather than another, to what conditions can we consider that what he chooses is something familiar or, on the contrary, strange to him?

The multicultural context has interested many anthropologists. Young (1990) in particular has shown how such a context reveals the limits of the applicability of the concept of "explanatory models" of sickness which gives place to a cognitive reductionism, associating a cluster of unscientific beliefs, considered out of context, with an ethnic group and to anyone identified to this group. He emphasizes that the medical beliefs of every individual are a combination of scientific and non-scientific knowledge.

To dispose of any misunderstanding concerning what we call Western societies, a remark about muticulturalism need to be made. Just as there is great variety in the foreign societies studied by the ethnologist so that they cannot all be understood in terms of a single model, neither can all the societies of Western culture be regarded as a single uniform block. If the phenomenon of multiculturalism has given rise to a criticism of the concept of culture, we may not deny that there is a diversity of cultures. The practice of anthropology on one's home field may not overlook genuine cultural differences. The tendency to treat Western society as if it were a homogeneous whole must be corrected by the effort on the part of anthropologists to recognize its fragmentation and to isolate its cultural constituent parts. I do not intend to rehabilitate any ill-founded culturalism

but I wish to stress that there are different symbolic systems, that each has its historical roots and that each is to be studied for its own sake.

There are no doubt subjects which can hardly be treated simply as "Western" or "foreign". The interrelatedness of human societies is such that they cannot be thought of as separate entities. The work of Farmer (1992) is instructive in this respect. He speaks of the spread of AIDS and of Western theories which pin the blame for it on Haiti. Behind this myth of the origins of AIDS lie a whole social history and a whole complex of international relations. There is more than scientific judgment involved in making Haiti responsible for AIDS. It is rather a political choice, a cultural construct, which, as Farmer's work shows, is not sufficiently open to debate. Noticing that even the distribution of AIDS reflects social prejudice, and Farmer (1998 [1995]) prefers to speak of "class differences" and the "North-South divide" rather than of specifically cultural phenomena.

Anthropologists do not see the importance of examining the Western medical system in the same way. For "critical medical anthropology", it is clear that criticism of the medical system must be explicitly political. M. Singer (1990) complains that medical anthropology can be turned into a servant of biomedicine, while its function should really be, not just to understand medicine, with its ideology and the contradictions which are inseparable from the capitalist system, but especially to change it. N. Scheper-Hugues (1990) is no less militant, regarding medical anthropology as a specific discipline with a particular battle to fight. Fundamental to critical medical anthropology is the idea that medical anthropology involves a critical analysis of the socio-medical context in which it developed (cf the special issue of *Social Science and Medicine*, 1990, about critical medical anthropology), and that the results of research cannot be separated from the social and cultural conditions in which they are produced.

One of the contributions of critical medical anthropology has undoubtedly been to inspire a growing number of anthropologists to pay more systematic attention to questions of medical ethics. This is not however to say that all the questions raised in this way are absolutely new. Some writers who denounce the social implications of medical anthropology seem to ignore the fact that there has for a long time been a critical current in French anthropology, especially in the Marxist circles associated for example with the name of G. Balandier. It is not only medicine that is being subjected to external critical examination in this way. Thus B. Hours (1998) examines humanitarian action as a social fact, a vehicle of power and an actor on the international stage. He thinks that the parts played in humanitarian action should be examined in all its complexity in order to uncover the social factors determining the behaviour of the actors and to reveal the real consequences

of what they do. The question of efficiency which runs through the whole of his work, is finally expressed in stark terms: Efficiency for Whom?

It is true, as M. Singer recognizes (1990), that critical medical anthropology has certain points in common with post-modernism. Both are interested in the social determinant of textual production, both recognize that language cannot be separated from politics, both ask questions about the grounding of ethnographical authority. In particular, both schools of thought are critical of the tendency of anthropologists to talk on behalf of people rather than with them, and both ask the question: knowledge for what? And for who? At the same time Singer observes that the major difference between critical medical anthropology and post-modernism is that the former has fortunately remained untouched by the doubt and loss of self-confidence cultivated by the latter. Singer even fears that this trend in post-modernism may lead us to the tunnel of depoliticisation and thus undermine the whole foundation of critical medical anthropology. In the same spirit Scheper-Hugues (1990) criticises what she calls the post-modernist policy of despair which amounts to leaving practice in the hands of those who embody the interests of biomedical hegemony.

One would not wish to deny the importance of the work of authors like Marcus and Fischer (1986) on the role of anthropology (see their criticism of the conceptual models used by this discipline). Nevertheless, it seems that the wind of post-modernism has finally blown itself out as far as medical anthropology is concerned. The reason for this may be the systematic deconstruction practised by the post-modernists which amounts sometimes to throwing out the baby with the bath water. Asking questions about the validity of current medical discourse and rejecting its categories is one thing, but the wholesale rejection of the categories of anthropology is another. This however is what the devotees of post-modernism tend to do. Thus, post-modernism may rather be identified with a kind of negativism, gnawed by doubt and guilt erected into a kind of doctrine which turns failure into a theory.

The self-criticism which produced post-modernism was of course valuable, but it must not be allowed to go to the extreme of placing a ban on all progress in our knowledge of human beings. It was legitimate enough to ask how far anthropologists could really escape from their own cultural categories and speak for alien societies. But this question soon gave rise to another concerning the real interest and public relevance of the issues studied by anthropology (cf Ahmed and Shore 1995), and concerning the authority of the anthropologists to speak and write about other cultures. Now the issue of relevance, actually raised with some relevance, has tended to muzzle however many researchers. The very question of knowing whether the text is not creating another reality than what is purports to describe,

isn't it likely to lead us to renounce to writing, and therefore to our discipline? There is no difficulty in recognizing that the economic and political implications must be taken into account. It is also true that the question of the use that is made of knowledge must not be evaded. This cannot mean however that we must abandon the attempt to understand what makes both the unity of human societies and their difference. (On this complex notion and about anthropology as “the science of difference”, see Van Dongen (1998) who reminds us how inappropriate the simple "we/they" distinction is now in a world which is continually creating new communities of insiders and outsiders, new patterns of interethnic relations, and new hybrid cultures.

The demand of the post-modernists that anthropologists must simply rely on the representations of the people they are studying can lead to confusion. One may indeed take people’s ideas as the starting-point, but it is essential then to go beyond them. To have an emic perspective is not to assume the discourse of the common sense. Or else how would scientific discourse differ from lay speech? It is no excess of positivism to think that there is some danger in denying the value of all the tools forged by our discipline. One may also think that such a position betrays a lack of proper humility. There is something narcissistic about the behaviour of the social scientist who deliberately abases himself by affirming that he has nothing to add to what the people he studies themselves say. It is of course true that studying other peoples teaches us a good deal about ourselves, just as studying ourselves helps us to understand other people; but some anthropologists seem to want to turn the windows through which they study other people into mirrors in which they can deliciously contemplate themselves committing intellectual suicide. This epistemological narcissism must not be confused with the attitude which makes use of the admittedly always imperfect tools of anthropology to criticize one’s own society. What is at stake in all this is nothing less than the health, the development and the sharpness of our discipline, as well as our knowledge of human individuals and human society.

Research carried out in the West has also benefited from questions arising out of ethnological studies elsewhere and which show the universal meaning and relevance of a number of themes. Thus Csordas and Kleinman (1990) have done valuable work in analyzing the therapeutic process in general and showing that its efficacity cannot be explained simply on the analogy of psychotherapy and religious healing. Besides, the issue of suffering, analysed by A. and J. Kleinman (1998 [1991]) as part of the ethnography of experience, has inspired a growing number of scholars, as far as it is one important phenomenological aspect of the experience of illness.

"Exotic" medical anthropology can make a particular contribution to the same science in the West by making it possible to take a fresh look at the categories used by medical science. This is of course a principal intention of the present work, in which the Africanist perspective is used to illuminate the situation in a Paris suburb. Ethnographical material is seen from another angle and some of the data may look very different from how they appear to scientific medicine. Notions like "prevention" and "contagion", for example, may sometimes be seen quite differently by the anthropologist and the health professional. People may not be surprised to find that exotic medical anthropology uses these terms to designate systems of representation which may be quite different from the Western understanding of their meaning; but they too seldom reflect that their meaning in the West needs also be reassessed.

We speak of "Western ideas", but of course these are far from being the same everywhere. People construct their own ideas about such things as prevention and contagion, and those ideas may have very little in common with scientific medical theory. Anthropology can use the study of Western societies as a proving-ground on which to refine and perfect such notions, and it will then be seen that concepts like prevention, contagion and effectiveness are far from being simply medical terms (Fainzang 1992, 1996a). They need deciphering, and this can only be accomplished when the anthropologist has succeeded in entering into the meaning of the concepts for the persons he is studying. The categories employed both by the medical profession and by common sense have to be continually redefined. This work of redefining the categories used by the medical community is all the more useful that, by creating distance from our objects, it allows for the refinement of our conceptual tools: it allows actually to make clear that these notions are of real interest for anthropologists as long as it is their social and cultural construction which is at stake and not the biologically proven reality of the phonomenon they aim at referring to. This work of endowing a true anthropological content to these notions is one way of sharpening the tools useful for understanding social and cultural realities.

The concepts forged in anthropological research in distant societies can therefore be fruitfully transferred to the study of Western societies by enabling us to see these latter with fresh eyes and to decipher the underlying symbolism and logic. At the same time however we must not abusively transfer to our Western studies concepts elaborated to fit a specific social and cultural reality elsewhere. Such an excessive extension could easily lead to a loss of understanding, for a concept may lose in comprehension what it wins in extension. So, unduly extending concepts reduces their usefulness, and applying them indiscriminately to new contexts may mean depriving them of their theoretical precision. If we think of terms like "tribe" or "ritual", it is

clear that they have to be used with great care if they are not to lose the precise meaning originally attached to them. Often furthermore the inappropriate extension of these terms does nothing to illuminate the subject to which they are applied. It is neither meaningful nor interesting, for example, to refer to a group of professionals like doctors as a “tribe”. On the other hand there may be scope for testing the validity of certain concepts and for tackling subjects not hitherto studied by social anthropology. This is illustrated below by the example of “recovering alcoholics”. In the same way, it is indispensable for us to re-think our categories in the light of what we know of other societies and to free these categories from the content assigned to them by the medical sciences, in order to consider their social meaning. Comparison is an important part of our discipline, for without comparing there can be no critical thinking. Nevertheless, all comparative work has to be undertaken with great caution. It is true that our concepts and categories often have only a relative character. By what standards, for example, do we judge that a certain condition is normal or pathological? Yet this recognition must not be allowed to collapse into cultural relativism. The proper attitude is not to regard our current concepts as cultural constructions fixed for ever, but as social constructions subject to variation according to the social contexts out of which they emerged or within which they were elaborated.

Conversely, it is to be observed that studies on what are called contemporary societies have made substantial contributions to a variety of questions of interest to general anthropology. Anthropological research in Western societies, for example, has encouraged reflection in the anthropology of genres applied to the medical field. Though the different treatment accorded to the two sexes is more manifest in traditional societies where there is a marked separation between men and women (Fainzang & Journet 1988), the ethnologist cannot fail to notice the fact that Western symbolic systems also attribute different social places, based on alleged psychological differences between the sexes, themselves underlied by representations of the body. Cayless (1988) shows how the explanations of disease offered by medicine have always presented women as emotionally and psychologically vulnerable, and the diagnosis and treatment of nervous disorders has been greatly influenced by the "ideologies of genre". In the last ten years the approach to phenomena from the angle of genre has been developed both in France and in English-speaking countries, in particular concerning the problems of AIDS. The knowledge which anthropologists have of the sharp social separation of the sexes in Africa has enabled them to uncover the social construction of the genres in the West as well. Some studies have analyzed how women have been either excluded from society or, on the contrary, given a prominent place in representations of AIDS and in the practices and policies of the anti-AIDS campaigns. They have shown the

inequality of treatment of men and women through the study of the representations associated with the body-fluids, of the social relations between the sexes, and of the social construction of sexuality related to AIDS, in Africa, in Europe and in the Americas. (Cf. for instance *Journal des anthropologues*, 1997; Farmer, Connors and Simmons, 1996).

In a similar way, the practice of medical anthropology in our societies has contributed to the development of the anthropology of health systems, for, in Europe as well as in Africa, research workers have been interested in analyzing the attitudes of health professionals with regard to AIDS. Special attention has been paid to the problem of announcing (revealing?) that one has the disease and of its social implications (cf Dozon and Vidal, 1993), to the process of taking the sick person in charge, and to prevention. Various studies on these questions have sought to define the attitude of anthropologists in the face of the phenomenon of AIDS and to determine the respective share of reflection and action (cf Broqua, Loux and Prado 1998), with a special attention to the ethical dimension.

The practice of Medical Anthropology in Western societies has also established it as a social science distinct from Public Health, by giving new meaning to certain notions, as can be seen even from the analysis of "health systems". From the point of view of public health, a health system denotes the whole complex of activities aimed at improving health. It covers institutions and professional workers, as well as administrative and financial support mechanisms. For anthropologists however a health system constitutes a whole social area which includes both professionals and patients and embraces a variety of representations of health and sickness. In addition to "official" medical care, medical anthropology is interested also in such things as self-medication, the resort to "healers", to "parallel medicine" and religious practices. All these institutions and practices have as their goal the maintenance or the restoration of health though they do not all follow the same logic. Bibeau (1995) has stressed the importance of involving anthropology and the social sciences generally in analyzing health systems and of adopting an approach which does not separate the system from the response it receives from the community. Anthropology adopts a less normative approach than that of programmes of Public health to which it can nevertheless bring useful tools. R. Massé (1995) has compiled a valuable handbook with details of the help which anthropology can bring to doctors. The volume offers a vast synthesis of the work which has been carried out, including the presentation of a study of health among immigrants in Quebec which illustrates the contribution which anthropology can make to public health.

The works in the field of public health have encouraged anthropologists to reformulate problems belonging to general anthropology such as the

relation between the local and the global. So D. Fassin (1999) reflects on the phenomenon of globalization in the realm of health, and more specifically to the interlocking connection between the small-scale local area, which is the anthropologist's normal scale of observation, and the wider global categories of his thought.

There is a number of sub-branches in medical anthropology which, benefiting from studies carried out abroad, have recently opened to investigation in our societies in ways which, in turn, have enlarged social anthropology in general. One of these sub-branches is the anthropology of medicines. This area was first structured by Van der Geest and Whyte (1988) on the basis of research carried out in developing countries. It has given rise to various studies in such matters as the prescription, distribution and utilization of medicines. The anthropology of medicines in France and in English-speaking countries covers today a wide field and deals with the major problems of public health common to both North and South: access to medicines, overmedication, use of medicines for non-medical purposes, the marketing of medicines, self-medication, the lack of compliance. The issue of compliance is no doubt one of the most commonly-treated subjects, though there are other areas which also deserve examining, especially if one recognizes how easily distortions can occur in an investigation into the carrying out of professional instructions when the study is limited to the doctors' point of view. Trostle (1988) has written of patient "compliance" as an ideology justifying and reinforcing the doctor's authority. The anthropological approach to medicines has also proposed analyses of their social uses and studies of the categories and social relations constructed around the production and distribution of medicines.

I'd like to mention here an example of a research which is a good illustration of how questions arising out of "exotic" anthropology can help to bring to light theoretical questions in our own society. It is a research which I am at present conducting on the representations and uses of both medical prescriptions and medicines in France. The idea of this research came to me through reflection on the special importance attached to the written word in the Islamized societies of Africa. The basic questions of my research are: What is the life of a prescription? What importance do the individuals concerned attach to what is written down? What is their relation to the doctor who wrote the prescription, and to medical authority in general? What are their concrete attitudes towards the medical prescriptions they receive? How do they manage in daily life both their bodies and their medicines? The study is then centred on the place of prescriptions and medicines in the life of the persons concerned, that is to say, the place they grant to them in the healing process and the place they give them in the domestic space. The use of the prescription condenses in the same time the attitudes to illness and

medicines, but also to the body, to the written word, and to the doctor. The findings are connected with the cultural (religious) affiliation or origine of the subjects (Catholic, Protestant, Jewish, Muslim)(Fainzang 1999).

The application of an africanist perspective to Western society makes it possible in this way to construct a new set of problems and so improve our understanding, not only of our own cultural world but of human societies in general by putting fundamental questions like the imprint of culture on social behaviour and bodily conduct. It means that an anthropology of medicines must not be separated from the whole anthropological project. It is not simply a matter of knowing and understanding the use which people make of medicines but also of perceiving what the use of medicines reveals about human individuals and human society.

Finally, my point is not simply a matter of contesting the validity of the "Great Divide" and to say that there is as much relevance in studying our own societies as in studying those traditionally associated with anthropology (even if the global challenge presented to the medical profession by the appearance of AIDS has rendered still more crucial the role of the social sciences and of anthropology in particular). The essential point I wish to make however is that if we wish to understand human societies, we have to make use of reflection on the data available from home as well as from abroad. We need the findings of “exotic” anthropology in order to understand what is happening at home, and we should also use our knowledge of our own society to look afresh at the material collected elsewhere. There has to be a dialectical movement to support the work of comparison, as regards both the construction of our objects and the concepts. There is no doubt that “exotic” anthropology has provided a treasury on which medical anthropology in the West can fruitfully draw, particularly in making it possible to see the familiar realities of every day in a fresh light. At the same time the findings of medical anthropology carried out in the West make it possible to formulate in fresh terms fundamental questions about the behaviour of human beings in society.

From Malady to Misery: An Anthropology of Recovering Alcoholics.

In the following pages I offer a summary of the research which I carried out, after my study in La Ville-Du-Bois, on recovering alcoholics. My aim was to take a specific illness, alcoholism, and by applying my perspective as an Africanist to its study, make a contribution to answering general anthropological questions (cf Fainzang 1996b).

It was while I was continuing my work in the field that I was led to

take a slight deviation and move from the study of illness in general to the “alcoholic illness” in particular. More precisely, I was interested in an association of former drinkers known as "Free Life" (“Vie libre”).

My first contact with the movement came through a female inhabitant of La Ville-du-Bois who invited me to come to one of its meetings. The meetings were attended by people who live in a number of different communes. This contact with Free Life, and the decision I took to continue it and make it the object of an investigation, meant that I moved out of the commune I had taken as my field of study and entered into a wider network of relationships. My field was in this way enlarged, but my interest was at the same time focused more narrowly on one of its aspects.

The centre of my concern remained the connection between the representations of illness and the therapeutic behaviour of individuals, but my research was now transferred to this association of former drinkers, to a world therefore structured by its special reference to alcohol and alcoholism. “Alcoholic illness” was the misery which brought the members of the group together. My study belonged therefore both to the anthropology of illness, and to the anthropology of misfortune, wished by Scheper-Hugues (1990) as a means to escape from medical reductionism.

What first attracted me was the fact that this movement’s teaching on alcoholism fitted perfectly one of the models of interpretation which I had previously identified, namely, putting the blame on society. The theory developed by this Movement is quite different from that of Alcoholics Anonymous. For Free Life, it is society that leads people to drink; alcoholism is a "social evil" and it is to be combated by attacking the way society is organized. As I studied this Movement, I was able to sharpen my vision of one of my accusation-models and perceive how this way of looking at alcoholism affected both the approach to therapy and the type of social behaviour connected with managing the illness. Though the Free Life movement is nation-wide and is represented in all the regions of France, my particular study however was carried out in the context of the investigations described in the body of this work and it sought to respond to questions raised therein.

Most ethnologists who are interested in alcoholism treat it as a life-style, or as the feature of a culture. I wished however to recover the original point of view of former drinkers and see alcoholism as an illness. I examined the struggle against alcoholism as itself a new culture, a way of life with its own rituals and values. My plan was to make a cultural study of a movement of former drinkers and to reflect on the meaning of abstinence envisaged as a value and as therapy. A large part of my research was devoted to studying the system of symbolic constructions produced by alcoholism in order to understand how the illness is thought of, interpreted

and fitted into life. What, I wanted to know, were the rules of this anti-alcoholism movement, and what kind of a coherent whole did they form?

It is to be noted that in the cultural context of this Movement, the members believe that it takes one alcoholic to understand another. One must have been an alcoholic oneself before one can understand the illness and help someone else to deal with it. The same principle is found in all associations of former drinkers. The struggle for liberation can only take place in association with other former drinkers. Their idea is that only those who have been sick themselves can understand those who suffer from this illness. There is an echo here of certain African healers who only become specialists in a particular disease because they have had it themselves. This is a special way of acquiring therapeutic expertise and it is an exception to the general rule of hereditary transmission. Its effect is to establish a body of healers with special competence in dealing with a disease of which they have personal experience. The principle here too is that one can only recognize a disease when one has had it oneself.

One part of my research sought to examine the theory of causality developed by this type of Movement in order to explain alcoholism. However, the explanations elaborated by members go beyond the official doctrine, for alongside that doctrine, there are individual interpretations of the illness. These interpretations also affect the subjects' conduct, since the way people see alcoholism and its causes determines what they do about it in terms of living a healthy life, avoiding certain situations and in the conduct of social life generally. I wanted to know whether the effectiveness of membership of an association like Free Life is dependent on particular theories of causality. How far does conversion result from a new perception of the causes of alcoholism and a new attribution of responsibility? We are here entering the wider field of systems of illness-interpretation (Fainzang 1994a).

It is commonly asserted in sociological and psychiatric literature that former drinkers do not seek to uncover the causes of their alcoholism. I disagree with this assertion. The subjects nearly always have an explanation to offer for their condition, even if they may not be prepared to divulge it within the framework of a formal interview. What may appear on the surface to be a refusal to examine the causes of their alcoholism does not mean that the subjects are unable to interpret it and uncover its causes. A distinction must be drawn between public attitudes, consciously adopted when the alcoholic is being questioned about his condition, and the deeper, more spontaneous attitude which emerges in informal conversation and in the actions of daily life, things which can only be perceived in the course of long observation.

Analysis of spontaneous conversation reveals an important difference

between the alleged causes of alcoholism in men and women. Men, it is said, catch the habit of drinking from others, while women drink because of psychological difficulties. Such explanatory formulas are gratifying to both parties. When men say that they are drawn into drinking by peer-pressure, they are projecting an image of themselves as sociable beings and pre-empting any accusation of weakness. Women on the other hand protect themselves from the unwelcome stigma of the habitual drinker by appealing to psychological vulnerability.

Individual members of Free Life have then recourse to a variety of expedients to explain their alcoholism. If however they are to remain faithful to abstinence, they must at least subscribe to the Movement's teaching that alcoholism is an acquired social habit which can be cured. The diversity of individual interpretations of alcoholism is no obstacle to the effectiveness of the Movement, provided that the subjects accept its basic teaching and admit that, in the end, the alcoholic is personally responsible for his or her condition. The Movement encourages such acceptance of ultimate responsibility by its willingness to adopt a flexible attitude to causality. This is an intellectual operation, but it is also a strategy. My research enabled me to perceive how different ways of speaking can co-exist with, and are interwoven within, the larger fabric of the Movement's official stance. The essential point is to accept the Movement's fundamental principle that alcohol is a kind of embodiment of society.

I was of course obliged in my research to tackle the question of the connection between interpretations of illness and therapeutic strategies. Different strategies were adopted according to the position given to alcohol in the causal chain. It was noticeable, for example, that men were more reluctant to take anti-depressants or to consult a psychiatrist, whereas psycho-active treatment prescribed by a general practitioner was more easily accepted. This attitude can be explained by a feeling that treatment offered by an ordinary doctor can be more easily seen as an operation to repair physical damage, including damage to the nervous system, whereas similar treatment prescribed by a psychiatrist would be felt as implying a psychic fragility popularly regarded as feminine.

I was able to make this analysis after a preliminary study of the symbolic representations of the physical effects of alcohol on the body, especially on nerves, brain and blood (that I studied in the same way as I would have studied the representations of the body in an African society) and of their impact on social behaviour (Fainzang 1995).

I cannot develop here all the results of my research and shall content myself with exposing some of the directions I followed, and with showing how the special tools and methods of ethnology, inherited from an African experience, can make a particular contribution to understanding this object.

One of the things I wanted to find out was how the Movement organized its activities to make them effective. What mechanisms did it use, and, especially, how did it seek to validate the necessity of abstinence? To answer these questions I observed the practices of the members of the Movement, both in their ordinary life and in special rituals.

I was then led to analyse one particular ritual which is fundamental for the Movement. Its aim is to integrate the sick person into the new group, the family of what they call the "cured drinkers". I investigated how this ritual encouraged abstinence by constructing a special identity of “a cured drinker”. I discovered that, contrary to what has been written about Alcoholics Anonymous, the identification of the new members to the ex-drinkers of the Movement doesn't imply that they should lose or conceal their own identity. Here too I was helped in my analysis of the material by the findings concerning African approaches to identity and anonymity (Fainzang 1994b).

In order to decipher the therapeutic strategies of individuals, I had to examine how they reorganize their existence in view of the overriding imperative of avoiding a relapse. How did the representation of alcoholism offered by Free Life determine the conduct of individuals, not only with regard to alcohol but also in his relation to the world? The attempt to answer this question involved looking into the social relationships of the drinker and asking both what effects his drinking had on his family and professional life, and what modifications had taken place as a result of his membership of the Movement. The relation between the subject and his illness is inseparable from his relation to other people, To understand this connection I undertook both an upward and a downward enquiry: upwards in considering how the members of Free life evaluate the different roles and responsibilities connected with the “alcoholic illness”; downwards, in asking how the subjects arrive at the determination to protect themselves simultaneously from the illness, from alcohol and from the other people in their life. This involved studying what alcohol represents and symbolizes from this perspective.

It is evident that the way different individuals handle their illness is largely determined by how they interpret it. The connection between the interpretation of the illness and therapeutic procedures emerges more sharply when one does not restrict the notion of therapy to scientific medicine but takes up a resolutely emic perspective which takes into account all behaviour judged as therapeutic by the individuals concerned. From this point of view, non-medical social practices deserve as much attention as those which are regarded as falling within the scope of medical anthropology. I tried to identify the principles which lay behind individual behaviour, taking into account the fact that the prime necessity of abstaining from alcohol as a condition of cure, and the image of alcohol developed by the group, lead the patient to elaborate his own therapeutic or preventive strategies and

so establish conditions for his cure which may happen to be pathogenic.

This however does not mean that there is a necessary connection between the subject's interpretation of his illness and the choices he makes. The interpretation of the illness is a complex matter which may involve appealing to a wide variety of elements. Moreover the meaning which the individual gives to his condition, or the cause which he identifies, do not necessarily lead in all cases to the same kind of conduct. The recourse to a particular therapy may be determined by a number of factors in addition to the search for a cure, so that the connection between the interpretation of the illness and the subsequent behaviour may not always appear rational.

On the subject of rationality, already raised above, I would like to emphasize what seems to me a central point about situations involving apparent irrationality. There can be a paradoxical relationship between different elements of behaviour which gives rise to paradoxical strategies. By this term I mean: either, firstly, practices intended to bring about a cure but which are in fact liable to aggravate the evil against which the subject is struggling; or, secondly, behaviour identifiable to therapeutic choices but directed at objectives other than a cure. The paradox resides in the gap between the representations of the evil and the motives which lead to the choice of a particular therapy and beyond, in the kind of effectiveness the patient is seeking. I made a particular study of this matter in Fainzang (1997), using data from a variety of cultural contexts.

There is paradox when the person concerned is playing simultaneously on two different logical registers in such a way that the resolution of one problem involves complicating another. A paradoxical strategy is not the result of a "double bind" but a response to another area of demand. There is no contradiction between the two demands but only between the conduct chosen and the hoped-for result. It is the inadequacy between two goals, because they are either incompatible or possibly antagonistic (but which cannot be reduced one to the other) that gives the strategies a paradoxical character. The choice I made to subsume the two types of situations under the same term is connected with the wish to thing together different conducts whose logic is not congruent with the search for healing but which all are directed towards an efficacy, whether or not therapeutical.

Finally I paid special attention to the spouses of former drinkers. This was because of the importance accorded to them in the teaching and practice of Free Life, and also because consideration of the domestic background showed me that spouses had a tendency to consider themselves as sick as the alcoholics themselves. They too claim they suffer, and their suffering is recognized by giving them a special status within the group to show that they too are involved in the problem of alcohol and alcoholism.

These considerations led me further into thinking about the meaning of

contagion which I chose to study with the same distance from the biomedical perspective as if I had to study an African theory of contagion. The notion of alcoholism as a "contagious illness" in the way it is understood by the subjects is an extension of the Movement's teaching about the condition as a collective illness. This does not imply that they ignore the ways alcoholism can arise. It is rather an expression of the perception of alcoholism as a phenomenon which affects physiologically and sociologically those who are in close social contact with the drinker (Fainzang 1996a).

My study showed clearly that the Free Life Movement, in the language it uses and in the social behaviour it encourages, constitutes a real culture, with its own thought-system and values. The adoption of these values and the acceptance of new semantic usages, such as the particular meaning given by the Movement to the word *freedom*, are put forward as conditions of recovery.

This study of Free Life has a rightful place in medical anthropology as far as the latter examines how groups of human beings respond, both theoretically and practically, to the experience of illness, and what their responses tell us about their relationship to the world. But this anthropology of illness is also an anthropology of misfortune. First, because, in the eyes of the drinkers, alcoholic illness constitutes the paradigm of misfortune and misery, involving psychological, relational, professional and material dimensions. Secondly and above all, because the modes of interpretation and management of illness in general are similar to those of any other misfortune. The procedure is to find out its cause and to eradicate or master it, even if illness has, for the subject, one characteristic which is its phenomenological dimension: it affects its body and is therefore always an indissolubly bodily and social event.

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