

# I

## Introduction

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### Medical Anthropology as Intellectual Career

#### At the Margin

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This metaphor figures in the title of this collection in several senses. It refers to the margin between anthropology and medicine as well as the boundary of Chinese and North American societies, where, since 1968, I have lodged my intellectual project. That is also the space of my professional career, and it is where I have spent much of my life. In the strict sense, the usage is accurate, even over-coded. Medical anthropology is at the margin of medicine; it is also at the margin of anthropology. A medical anthropologist in the field of China studies is also at the edge of the mainstream disciplines and professional interests. To write about medicine in 1994, moreover, yet not locate oneself in the national debate on health insurance in the United States is surely to make a statement about another kind of margin, a border that, as the *Oxford English Dictionary* puts it, differs “in texture from the main body.” This collection of essays explores that difference in medicine’s cultural, political, and phenomenological texture.

The part of the definition of the margin that does not, I hope, apply is “a condition which closely approximates to the limit below or beyond which something ceases to be possible or desirable.” To write

at the margin is not necessarily to be marginal in that sense of having nearly passed the limit of viability or relevance. It would be bizarre indeed for a professor who heads a large program, has received grant support for his research, and has chaired key committees in health and social science, to claim marginality.

That is not my meaning. Rather I find myself inherently uncomfortable in the center and suspicious of the mainstream, even when that specifies my professional location. A sense of resisting, going against the grain, comes naturally to me. Being at the margin, perhaps at times even at the brink, may, of course, be making a virtue out of necessity, because a quarter century's experience as an intellectual in American society has taught me that I am at the sideline, not in the center of the field of play. Perhaps as a Jew in this century of the Holocaust, I would have felt marginal in any case. Psychiatry, chosen as my clinical specialty after I had begun to study anthropology, is regarded as marginal by the rest of biomedicine, and a cross-cultural and international approach is regarded as marginal by many within psychiatry. Anthropology, as experience has taught me over the years, is in a truly crucial margin between the humanities and social sciences. Thus, for personal, ethnic, and professional reasons, the margin holds superabundant significance for me. But then again, if Anthony Giddens (1991:6–8) is right about the consequences of high modernity, marginalization—in his terminology, “the sequestration of experience”—is everyone's destiny.

Writing about the hidden relationship of autobiography to philosophy, Stanley Cavell (1994) concedes that the pitch or voice we come to arrogate as our scholarly life matures is made out of the special tone of genealogy and the body's remembrance of formative events. Of his own pitch of philosophy, Cavell writes, “I have seemed to myself fated to take what appears as eccentric perspectives, as it were to remain between, to refuse sides” (p. 13). Cavell sees his task as writing against the curious resistance of academic discourse to authorize this kind of self-referential writing. If Cavell is right on this point, and the psychiatrist within my anthropological skepticism intuitively feels he is, then my own fate was to possess what connects yet is utterly separate—sealed as a son who never met his father, a grade school student who bore two utterly separate family names, from two opposed sub-ethnic factions, one in public school, the other in religious school; a scion of a mysterious past about which his Victorian family was silent or whispered inarticulately, so that I had the extra developmental task of fig-

uring out by myself, yet not announcing to others, lest they be hurt, what identified me, which therefore could not be authorized (or denied). My past prepared me to mediate, not through assimilation or accommodation, but by way of existential engagement with different interpretations of constructed differences. I occupy the margin not out of refusal to choose sides, but because I am bound to both, and at the point of their engagement, in order to discover what they are (or are not) and I am, or am not. Hence, the margins I seek are unfinished, even already overstepped, and become something altogether different out of interaction.

While references to neither safety margin nor profit margin (alas) seem apt in my experience, the idea of the liminal—the border as a threshold—does feel right. The margin between social theory and the ethnography of social suffering is a space of vital liminality. It is a threshold to something new, an unoccupied no-man's-land open for exploration. Such a liminal position can animate a critically different reflection on medicine and society, a reflection that need not accept things as they are. And it is in the liminality of illness, poverty, and other forms of human misery that I have found the subject that animates my world, morally as much as professionally. My subject itself, then, is the margin and the marginal.

I might even be willing to accept the idea of “marginal man” as an epithet, if the idea of living in two diverse cultures, two different ways of being-in-the-world—which has been my way of life—is separated from an insistence that it imply an “unstable character.” This kind of lived marginality can stabilize; it can even bring a kind of solace.

I would remove the “of” in the cliché “of marginal importance,” which derogates something that should be respected: namely, *a small importance*. Scholarship is probably almost always a small importance. Rarely is it an earth-shattering breakthrough. But that does not mean it is of no importance. Scholarship stands for changes and possibilities that widen the intellectual horizon as well as the space of experience. That makes its importance decidedly human. Over time, of course, small though those changes be, they do come to stand for a good deal.

Like scholarship, life itself is a small importance; we live in the margins and at the margin of great events and processes. Children, as the Chinese delight to put it, are little treasures, little happinesses, small importances. So are we all. It is also in the margin of disability that therapeutic change may make a small difference that becomes all the difference in a person's life, a small importance that repairs, rebuilds,

reinvigorates, reinvents. Healing usually is transformative at this margin of small yet crucial changes in bodily processes that have social effects. Experience too is about small, local things: including edges and brinks. Unlike depth psychology, the phenomenology of social experience is about surfaces and boundaries, many small importances.

And then, of course, there are marginalia: marginal notes, references, footnotes, figures in illuminated manuscripts which literally step out of the text and come alive in the margin. Scholars spend much of their careers writing in the margin. We write on the sides of manuscripts sent to us for review, in the margin of published volumes, at the bottom of term and examination papers. I like this image because it so thoroughly connects scholarship with intellectual exchange and teaching. In the marginal notation, those three sides of academic experience really are inseparable. Many of the best moments in my scholarly career have come when I could use marginal notes to invite beginning students into a scholarly discourse that was new to them or when there was an occasion to deepen the work of advanced students. I have sometimes felt a moral meaning in the marginalia others have scribbled on my manuscripts, including this one, insisting that the treatment I had given a subject could be different and better. I have tried to bring such a purpose to my own reviews.

It is lamentable that scholarship in medical anthropology, as in anthropology and medicine generally, has thinned out in the current epoch of quick reading and even quicker communication. Authors summarize the contribution of a colleague in a phrase or single sentence, writing a slogan in place of an analysis. I have been treated to this unscholarly strategy more than a few times, and I confess to committing the same delict at least as frequently. While the misprision of the "anxiety of influence," as Harold Bloom put it, is understandable, poor scholarship does violence and should be unacceptable. In chapter 9, I end this book with an old-fashioned review of the literature, allotting enough space for the review of recent ethnographies in medical anthropology to give prominence to the words of the authors and to the intricacies of their interpretive work. I sought to create a review that would do justice to large, complex monographs, and thereby can contribute to the scholarship of the field I have come to inhabit, and that inhabits me. It is no accident that the review is placed last, at this volume's final margin. I could have extended even such a long chapter, and I emphasize that it is unfinished; it points toward the future as a responsibility. We have the responsibility to come to terms with the work

of others by deepening disciplinary conversations that grow more substantial and interesting as we engage in their fullness other voices, other visions, and as we come to appreciate the dialogical relationship of our own writings to those of others.

Living and writing at the margin of the wider society, whether it is our destiny or not, can be a statement about what is and what is not at stake. Perhaps it is only at the margin that we can find the space of critical engagement to scrutinize how certain of the cultural processes that work behind our backs come to injure us all, constraining our possibilities, limiting our humanity. And perhaps it is at the margin, not the center, where we can find authorization to work out alternatives that can remake experience, ours and others. In that sense, I suppose, the margin may be near the center of a most important thing: transformation. Change is more likely to begin at the edge, in the borderland between established orders.

However I characterize it, this book of margins, a kind of oblique life of ideas, shares this much with Montaigne's (1992) essays. Like him, I could say, "I have no more made my book than my book has made me—a book consubstantial with its author, concerned with my own self, an integral part of my life" (p. 504).

### Rereading My Work: Continuities, Discontinuities, Unexpected Change

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My first publications in medical anthropology and in the China field appeared in a cluster in 1973. Reading the titles today—"Medicine's Symbolic Reality"; "Toward a Comparative Study of Medical Systems"; "Some Issues for a Comparative Study of Medical Healing"; "The Background and Development of Public Health in China"—I am lulled into a sense of abiding continuities.<sup>1</sup> The themes run like a deep current through my intellectual career. Yet, when I reread the prose itself, the sense seems not so much false as inadequate: an illusion disperses, yet leaves a residue, an ambiguous trace. For while the thematic consistency is there, the work of interpretation, even the writing, is very different.

The essays assembled in this collection are written two decades later. The involvement with Chinese society, with healing, with the culture of medicine continues. But the commitment to a comparative

project has turned away from medical systems—the very idea, with its impression of formal structures and innate divisions, now makes me uncomfortable—toward the lived experience of suffering, toward medical practice as a historicized mode of social being-in-the-world. While I have no desire to deny my roots in symbolic anthropology, an equally long-standing concern with phenomenology has intensified. I also have moved from a preoccupation with symbolic forms and social structures, first toward subjectivity and then on to the intersubjectivity of experience. In my writings, narratives have supplanted models. Medical and psychological categories, which were not mine, have given way to the ethnographic interpretation of intersubjectivity, which feels more authentically like my own way of proceeding. In contrast to what is supposed to happen, and even to my original intention, I started, curiously enough, with comparisons and ended up more and more with particular contexts. All the while, it seems as if I am struggling to find new words and new images to evoke the same recalcitrant *processes* that cross between social space and the body.

In late 1979, the University of California Press published my first book, *Patients and Healers in the Context of Culture*. Widely reviewed and commented upon, the book seemed to take on a life of its own. A generation of graduate students, it seems, was trained in medical anthropology in criticizing its contents. Whereas its contributions perhaps were at first overemphasized, later on it was identified primarily by its shortcomings. Perhaps this is one socio-logic in the career of academic books. Now fifteen years later, new readings of *Patients and Healers* seem to have a more balanced ring.

The book surveyed much of what was then known about medical systems cross-culturally: a difficult but still possible task at the end of the 1970s. In the mid-1990s it seems both less feasible and less desirable. The book took a strong social constructionist position, a position I continue to hold. *Patients and Healers* also was animated by a clinician's gaze. While I was writing the book, I was in active clinical teaching and practice. Because over the past fifteen years I have spent much more time in the anthropology seminar room and much less in the clinic, that orientation is not as pervasive today. In 1980, I found a cognitive orientation useful as a method of relating collective and personal processes. By the mid-1980s, I no longer found that approach congenial, principally because it overcodes one side of experience at the expense of all else and because it fits too neatly into rational choice models that I reject. My emphasis had also shifted from disease cate-

gories as an epistemological object of cultural inquiry to the experience of suffering as the object of cultural ontology of everyday practices. And yet, *Patients and Healers* draws from a quarry that I have continued to mine for ideas and materials about patient and practitioner relations, the healing process, and medicine in Chinese society. The quarry itself can support certain mining procedures better than others. Chinese materials made the study of intersubjectivity and sociosomatics unavoidable. (See chapters 5, 7, and 8 below.)

*Patients and Healers* is motivated by questions large enough to found a career research program.

How can we elaborate an ethnomedical model that can systematically compare different culturally constituted frameworks for construing (and thereby, at least in part, socially constructing) sickness? What would such a model require to be able to provide both accurate phenomenological accounts of the way sickness is experienced in different cultural settings and valid hermeneutic accounts of divergent and perhaps conflicting interpretations of sickness? How would such a model enable us to make cross-cultural comparisons of the way therapeutic responses to the same type of sickness are differentially organized by various lay and practitioner perspectives? And how would an ethnomedical model determine which are the core clinical tasks of healers in different cultures? (p. 18)

This question framework sponsors a set of narrower questions to guide field research:

What are the range of clinical phenomena in a society? How do they relate to systems of cultural meanings and norms on the one hand and institutionalized social patterns of power relations on the other? How and to what extent do cultural conceptions about sickness influence the prevalence, morphology, and course of particular disorders? In what ways do differing cultural views of sickness and treatment affect clinical communication between patient, family, and practitioners? What are the culture-specific and universal characteristics of the healing process? (pp. 18–19)

Today, I am uncomfortable with the style and even the preoccupations of “models,” ethnocultural or other, which imply too much formalism, specificity, and authorial certainty, but models were definitely in my mind in the 1970s, a residue of symbolic and structuralist readings. While I have moved away from models, I have continued to hold the notion that to examine the clinical realities constructed in different societies and institutions is no more a form of essentializing or naturalizing research enquiry than is the study of kinship, religion, or economics. Yet, I would not now write so readily about “core clinical

functions,” both because I am much less certain what they are and because the functionalism of the term rings an alarm. While much new research deepens our understanding of several of the empirical questions, it is impressive how little we still know about cultural constructions of the course of illness or about shared ingredients in the healing process.

In the late 1970s I could write with assurance,

The single most important concept for cross-cultural studies of medicine is a radical appreciation that in all societies health care activities are more or less interrelated. Therefore, they need to be studied in a holistic manner as socially organized responses to disease that constitute a special cultural system: the *health care system*. In the same sense in which we speak of religion or language or kinship as cultural systems, we can view medicine as a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions. In every culture, illness, the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all systematically interconnected. (p. 24)

The idea and cadences are mine, but the blueprint is Clifford Geertz's; it now sounds too complete and deterministic. I, like many others, doubtless including Geertz himself, have become less impressed by systematic connections and more by differences, absences, gaps, contradictions, and uncertainties. Nonetheless, in spite of the postmodernist sensibility, the idea of a symbolic bridge connecting personal and social space has continued to animate my work right through the essays in the second part of this volume.

About “explanatory models” of patients and practitioners, however, I have become much more ambivalent. I introduced the idea as a way to get a rough-and-ready sense of what is at stake for participants in medical dramas. It has proved useful in the clinic, where time prevents even a mini-ethnography, and it continues to be applied in research. But I am extremely uncomfortable when it is misapplied as an entification of medical meanings as “beliefs”: things that can be elicited, often outside the vital context of experience, like the reading of the pulse, and coded as a clinical artifact. I meant the explanatory models technique to be a device that would privilege meanings, especially the voices of patients and families, and that would design respect for difference. I intended it to be a *modus operandi* to get at what is at stake in suffering, but also a method that would give anthropologists and clinicians access to the working knowledge of the practitioner as the bearer of the cultural orientation of biomedicine and, therefore, the source of



potentially dangerous misrecognitions. I saw explanatory models as a methodology for clinical self-reflexivity, for pressing against biomedical crystallizations, for laying hold of the sources of clinical miscommunication. I wanted to encourage the use of open-ended questions, negotiation, and listening, not the usual mode of clinical interrogation. Clinically the explanatory model approach may continue to be useful, but ethnography has fortunately moved well beyond this early formulation.

*Patients and Healers's* critique of biomedicine for its ethnocentrism, its reductionism, its essentialism, and its failure to engage the life world of patients recurs throughout my work, as in the next chapter. This I still take to be the deep cultural source of much that is untoward in medical education, research, and practice. Yet my approach to *somatization*, which was one of the sources of that critique, has changed greatly. I now find the earliest formulation too tied to a disease/illness distinction, which becomes less and less tenable, and it is overly psychiatric in its concern with the psychophysiology of depression and the psychodynamics of displacement. Somatization seems normative and often normal; it is not so much a substitution for something more basic as it is a basic way of being-in-the-world. The original formulation also seems to imply a too-simplified cognitive connection between language and the emotions. Since 1986, I have dropped "cognitive coping processes" from my vocabulary, and overall have become less interested in putative psychological universals. Somatic modes of experience now seem to me better understood in a sociosomatic language.

*Patients and Healers's* studies of family-based treatment, practitioner-patient interactions, and the healing process offer other examples of the continuities and discontinuities in my work. The research on family-based treatment explicitly argued that anthropologists had turned away from mundane everyday responses in the household and neighborhood in favor of more dramatic ritualistic treatments that sometimes provided an aura of exoticism to the study of healing. The study I undertook of the everyday experience and ordinary response to illness is one I still find important and, regrettably, this type of study is still less common than studies of ritual healing. However, the deconstruction of help seeking into distinctive types of resort, together with the diagramming of steps in the process of choosing a caregiver, now seem overly mechanical. Similarly, while the attempt to categorize practitioners with respect to time, space, institutional, and interpersonal

aspects of clinical reality remains promising, I no longer am certain that the particular metrics I employed are all that useful. This is an approach I keep coming back to, however; I can't seem to let it alone. It is as if the rich ethnographic detail about clinical encounters itself points to there being something of importance there, but I am uncertain what it is or how best to study it.

Much of what I have to say about efficacy—that it is complex, differentially constructed, even contested in experience, and needs to be examined simultaneously on several levels—I can still stand behind. The question of efficacy hinges on the analysis of cultural processes that continue to be a tantalizing reminder of what medical anthropology might contribute. Yet, the study of a few detailed cases produced a conclusion about the performative bases of efficacy—namely, that cultural healing always must succeed, at least in symbolic terms—that a study I conducted more systematically with a larger sample from 1977 to 1979 contradicted. It is disconcerting that the later study continues to be one of only a few that systematically assess the efficacy of indigenous religious healing (see Kleinman and Gale 1982); it is as if medical anthropologists find it difficult to take on this particularly cherished convention. I too have occasionally misrecognized these findings in settings where alternative healing required defense. (But the review of recent research by Thomas Csordas [1994] and others in chapter 9 suggests important exceptions.)

Montaigne in his classic essay on inconsistency points out that

those who make a practice of comparing human actions are never so perplexed as when they try to see them as a whole and in the same light; for they commonly contradict each other so strongly that it seems impossible that they have come from the same shop. (1992:239)

“We are all patchwork,” continues Montaigne. He could very well have said the opposite too. We are all also much of a whole. My own work seems to be both. I went through a sea change, though, shortly after publishing my second book, *Social Origins of Distress and Disease* (1986), which reported on a series of studies carried out to understand the relationship of neurasthenia, depression, and chronic pain to each other and to the Cultural Revolution and other major political and social changes in Chinese society. Before discussing the nature of that change, I should perhaps say something about *Social Origins*.

In writing that book I came to explicitly interpret somatization as an idiom of interpersonal distress, a form of cultural experience rooted

as much in political and social structural processes as in clinical ones. Depression, too, I recast as a relationship between person and society. My intention was to deepen the study of “a sociosomatic reticulum (a symbolic bridge) that ties individuals to each other and to the local systems within which they live” (p. 1). I tried to position the analysis so that it centered on this sociosomatic dialectic between symptoms and society, because that is where Chinese cultural processes pointed. The goal was to develop a methodology suitable for anthropological psychiatry and psychiatric anthropology. Like *Patients and Healers*, this book combined narratives and numbers.

At the time *Social Origins* appeared, there were only a few other studies of political trauma, especially during the Cultural Revolution, in the Chinese mainland, a subject that in more recent years has attracted much attention. What started out as a study of the social origins and effects of illness quickly extended to social suffering generally, as it became apparent that neurasthenia was an experiential mode that expressed a variety of different forms of distress. Explicit comparison of neurasthenia, depression, and somatization in Chinese culture and in North American society organizes at least half of the book's chapters. Among the organizing questions were several that aimed at contrasting neurasthenia as cultural representation and neurasthenia as social experience:

- Did the collective behaviors and experiences subsumed by neurasthenia as an illness category decline in the West and greatly increase in China? Or is it a matter of change in the usage of the category?
- Is there something about rapid and disruptive societal transitions—both the long-duration transition of social structures toward modernity and short-duration political and economic transformation—that either place individuals at greater risk for the life problems and bodily dysfunctions mapped by neurasthenia, or that simply encourage the use of this idiom of distress? (p. 35)

This book also signals the beginnings of a shift from treating clinical depression in a disease model to placing it in a much broader array of social suffering. I examined the Western construction of a deep subjectivity in the person as a concomitant to the Western cultural program of rationalization and commented on its global influence. Critiquing psychologization in the West establishes somatization as a different object of enquiry. The body becomes a mediator between individual and collective experience. Affect, then, needs to be examined

as the bodily nexus of social relational, moral, and political connections: “to feel is to value or devalue, to connect with or stand apart, to act in resistance to or to be paralyzed by our embodied social circumstance and our socially projected bodily experiences” (p. 177). Rehearsing my founding interest, I pressed an interactionist view, albeit one that now seems to me to make too grandiose a claim of systemization, in which “culture enters into this picture [of depressive emotion] as the *systematized relations* between physiology, feeling, self-concept, body image, interpersonal communication, practical action, ideology, and relationships of power” (p. 179).

Perhaps the book’s most salient conceptual point is the idea of a double mediation of distress and disease based in the placement of local worlds as intermediary between the pressure of political movements and other large-scale forces of social change on one side and the resistance or vulnerability of individuals on the other. The second mediation is the body’s transformation of that locally refracted force into normal and pathological reactions. How the two processes interconnect became the grounds for linking a social theory of sociosomatics to psychobiological theorizing.

But rather than return to a focus on individual cases, *Social Origins* builds upon the quantitative findings and narratives to discuss their societal implications. The antecedents of the report *World Mental Health* that my colleagues and I have recently prepared emerge from this reconstruction of the object of enquiry:

We now have in hand . . . persuasive findings that mental health problems—suicide, substance abuse, violence, admission rates to mental health facilities, depression and certain other psychiatric disorders, family pathology—also worsen under conditions of social disorder, economic deprivation, unemployment, forced uprooting, and migration. Like health problems in general, mental illnesses and social pathology have their highest prevalence among those in the lowest social statuses in society. . . . There can be little doubt that the health consequences of human misery are most effectively improved by significantly altering the macrosocial sources of misery. But the argument of this book is that local systems mediate the effects of macrosocial forces on groups and individuals, such that in settings of deprivation not all groups and individuals suffer to the same extent. Certain social statuses (the poorest, the least powerful, the stigmatized, those experiencing systematic discrimination) place individuals at greater risk for human misery and its health consequences. (1986:181)

This was my warrant to examine the Cultural Revolution as political violence and to study its traumatic effects on ordinary lives. The

survivors' tales I included in the book, though, simply would not sustain too limited a sociosomatic framework. They insisted upon the broadest linkage between the political, the moral, and the bodily as a defining human process, an existential web of continuity and transformation. That conclusion continues to challenge my ideas, as can be seen in each of the chapters in the second part of this book.

I asked Comrade Yu if her major depressive disorder could have resulted from marital incompatibility and strain that only emerged once she and her husband were reunited. She disagreed with this formulation and offered an alternative one—a striking metaphor that I will now paraphrase. Suppose, she said, looking to the ground, you were climbing a mountain and this mountain was very steep and terribly difficult to climb. To the right and left you could see people falling off the mountainside. Holding on to your neck and back were several family members, so that if you fell so would they. For twenty years you climbed this mountain with your eyes fixed on the handholds and footholds. You neither looked back or ahead. Finally you reached the top of the mountain. Perhaps this is the first time you have looked backward and seen how much you had endured, how difficult your life and your family's situation had been, how blighted your hopes. . . . She ended by asking me if this was not a good enough reason to become depressed? (p. 141).

A study that had started as a clinical project had become a project on political violence. Research that began by avoiding the category fallacy—imposition of a classification scheme onto members of societies for whom it holds no validity (Kleinman 1977)—ended by running up against the experience fallacy—imposition of a mode of experience onto members of societies for whom it is not a valid form of life. The epilogue of *Social Origins* tellingly looks in two directions: toward the cultural phenomenology of bodily modes of suffering as collective experience and toward the cultural ontology of the relational self within the historical particularities of Chinese society. Both subjects—the one, cultural bodies; the other, historicized selves—are carried forward in the essays in this book.

The transformation that followed *Social Origins* originated in stories like that of Mrs. Yu which came alive in the margin of the research chapters as a subject larger than the technical one I had fashioned. These accounts stepped outside the pages. The narratives could not be confined by professional classification or clinical purposes; like pictures at an exhibition of the ordinary terror of life in a brutal time, they jarred me profoundly, these narratives whose suffering I could not shake off. They came to reshape the very way I heard patient accounts, the way I thought about my work. What, after all, was it for?

What constrained an overweening anthropological vision of culture so that space was left for the intimate and the intolerable? I followed up the existential turning point with a “popular” book, *The Illness Narratives*, written as much to exorcise these ghosts as for practitioners, patients, and their families. *The Illness Narratives* told stories of sickness much as they had been told to me. I felt a deep compulsion to retell these accounts, most of which came from my clinical experience in North America, not as “clinical histories” but as moral tales of remorse and regret, as social dilemmas, as cultural ironies, as the imperative stuff of myth and tragedy. For me that was a pivotal transformation of what my work was about and what I was for.

At that time, I was only partially interested in the theory of narratology and in the mechanics of narrative analysis, things I learned much more about after I had written *The Illness Narratives*. The book was an existential signifier along the peculiar path I had taken, and, in Michael Jackson’s (1989) evocative phrase, that path had led “toward a clearing.”

I had more or less found my subject, or it had found me. I worked to control my engagement with the anthropology of suffering in *Rethinking Psychiatry: From Cultural Category to Personal Experience*, where I tried my hand at restating the core questions of psychiatry (What is a diagnosis? Are psychiatric disorders different across cultures? How do cultures and social institutions create a social course of illness? How do they shape the practice of the psychiatrist? What is clinical efficacy?) so that my engagement with suffering did not overwhelm the cultural analysis and cross-cultural content that I needed to privilege to write a psychiatry book. But my preoccupation with the moral and political sides of suffering became so apparent in chapters 4 and 5 of *Rethinking Psychiatry*—the chapters covering the work of the practitioner and the performance of illness—that, at least on my rereading, those chapters overshadow a book that was supposed to have more to do with showing how a cross-cultural perspective alters our understanding of what is a diagnosis, a prognosis, a case, and a treatment.

In an ironic turn that almost became farce, as the second editor of a long-planned collection, *Psychosocial Aspects of Depression*, a carryover from my years at the University of Washington, I bridled at a technical construction of depression. My sensitive though dismayed coeditor, Joseph Becker, one of the great scholars of the subject, allowed me to write what amounted to a separate introduction that dissented

from his and from the position of most of the authors whose work appeared in the collection. I could no longer write about suffering as the experience of clinical depression; I needed to write about depression as existential and collective, only one particular form of human misery, and not necessarily the same form in different places.

## Essays Written in the Margin

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That personal and professional scruple led to the composition of the essays on the experience of suffering in this book, where I, together with my collaborators, have had three goals. First, we seek to redefine suffering as an interpersonal or intersubjective experience: social suffering. The theoretical horizon carried over from the essays in part I privileges interactions in the social network, bodily metaphors of societal memory, struggles over the authorization of professional and political representations of suffering, and moral resistance to certain of those authoritative meanings. Out of these cultural processes, my North American and Chinese colleagues and I argue, comes a way of examining human problems that connects anthropological and other humanistic modes of interpretive enquiry with health and medical concerns. We struggle with a way of interpreting interviews, narratives, ethnographic observations, and even survey findings against this intellectual horizon. The materials we work with privilege the experience of recalcitrant human problems over which we have (and can have) only limited methodological grasp. Thus, we come up against the confines (and even the risks) of knowledge. Second, we put in that category of social suffering every different kind of human problem that creates pain, distress, and other trials for people to undergo and endure. We do not, for example, separate illness from political violence or from other forms of misery. Third, we have a go at applying different social theories to better understand the “social course” of suffering and its consequences for social life: for example, how chronic illness possesses not a “natural” but a social history, a moral career. As a corollary, we attempt to balance a therapeutic language with one that privileges normative moral conditions along with societal action.

Our chief concern is neither methodological nor metaphysical. We seek to explore experience—social experience—as a stream of enquiry. Does sustained engagement with the varieties of experience of

suffering offer distinctive possibilities for research? Is the framework of social analysis of experience a significant way of doing social theory? Are there potential implications for policy, programs, and practical interventions? Is social suffering a coherent subject? Does our approach to this subject, preliminary as it is, offer novel and interesting insights? The reader can also explore alternative ways of pursuing certain of these, and related, questions that other medical anthropologists have followed, a large and illuminating landscape that I survey in the book's third and final part.

In future, I will explore in more depth the closely related question, What difference does it make—for theory, for research, for policy, and for societal ethics—to change the border between a social and a health problem? Now pulling the edge toward the social side, later on pushing it toward the medical margin—does that disclose a comparative advantage for “medicalization” of human misery under certain conditions, or for “socialization” under others? The moral, the political, and the medical are culturally interrelated, but how do we best interpret that relationship and its implications? This question is partially touched on in this book. I expect it to receive an even broader intellectual horizon in my work in future.

The collection of essays, in sum, follows the three tracks along which my writing has traveled over the past several years. The first (chapters 2–4) is a path of critical engagement with the deep cultural processes that are at work within biomedicine. I extend that cultural critique from biomedicine's peculiar form of rationality and process of knowledge generation to its influence over the development of medical ethics, which originates in the same deep cultural strata. That sovereign cultural frame also shapes the issue of “objectivity” as a central motif in international public health. My concern in each case is not with the obvious strengths that result from this core cultural orientation. That story is overcoded in Western society and now globally. Rather I seek to show how these cultural processes limit biomedicine as a science and form of practice. Ethical deliberation about health care and medical technology is also seriously constrained. And the very way the closely related fields of international medicine and social development go about formulating policy and programs for low-income societies suffers from the same source of limitations.

Perhaps the chief contribution that medical anthropologists can make to these fields is not primarily to assist them to engage different ethnic groups and function more effectively in different social contexts—the