

Between Structural Violence and Idioms of Distress: The Case of Social Suffering in the French Caribbean

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ABSTRACT: Structural violence has become a central concept in critical medical anthropology. It emphasises the importance of structural health determinants such as poverty, political violence and other collateral aspects of globalization. Diseases and epidemics are viewed as being pathologies of power. The goal of anthropology is no longer to analyse the influence of culture on illness and disease, but rather to engage in pragmatic efforts to remedy social inequalities that express themselves through ill-health. Such opposition between culture and politics may not be consistent with the need for a comprehensive anthropology that emphasizes the subtle and complex articulations between the multiple dimensions of health. Based on an analysis of depression and social suffering in postcolonial Martinique (French Caribbean), a plea is made for a new understanding of the relationship between local idioms of distress on the one hand and intermediate social, political and economical factors on the other. There is also a discussion of some of the pitfalls related to an exclusive focus on the political economy of health.

KEYWORDS: structural violence, pathologies of power, Martinique, social suffering, depression, post-colonialism, idioms of distress, Caribbean.

Introduction

In the past few decades, the political economy models of health have gained ascendancy in medical anthropology. The focus is no longer on the impact of culture on the social constructs of health, disease, medicine and traditional healing practices, but rather on structural factors affecting living conditions and access to health services such as poverty, discrimination, political violence and war. Emphasis has been placed on what has become known as 'structural violence' (Farmer, 2004), an alternative critical approach to traditional interpretative theories, so as to better account for the ethnographically visible manifestations of poverty. Epidemics such

as tuberculosis and AIDS in Haiti are analysed through the pathologies of power (Farmer, 2003). The goal of this paper is to discuss the contributions, as well as limitations, of this concept, based on an analysis of mental health in Martinique. As will be discussed below, the post-colonial context of the French Antilles also creates structural conditions in which mental illness and social suffering take the form of identity crises and feelings of vulnerability.

The challenge for medical anthropologists is thus twofold. Firstly, to link the macro-sociological analysis of mental suffering with an ethnography of the daily living conditions. Secondly, to understand the interactions between the historically-based economic and political

structural violence and a cultural or symbolic violence. As suggested in a recent literature review of postcolonial studies, the main challenge is to transcend the old analytical models of postcolonialism by positing new forms of critique that address 'the ideological and material dimensions of contemporary neo-imperialism'. (Looma et al, 2005: 4). This leads to a new critical language for articulating the link between local, lived experience and the broadest structures of global economic and political power (Looma et al, 2005: 19).

Some anthropologists have suggested a 'third approach', seeking a broader, multi-level analysis through medical anthropology. The challenge here is to integrate the local and global, cultural and political dimensions of health determinants. It is to take into consideration the weight of history as well as the strategies for the daily management of suffering. Concepts that include 'symbolic violence' (Bourdieu 2000), 'social suffering' (Kleinman, Das and Lock 1997) and the 'violence continuum' (Scheper-Hughes and Bourgeois 2004) (see Bourgeois and Scheper-Hughes 2004 for an analysis) broaden the structural violence approach. Despite the interest evinced in an integrated, multi-dimensional approach, however, there seems to be a trend in a significant proportion of recent publications towards an approach that only considers the economic and political dimensions. What are the pitfalls associated with such a trend? What are the contributions of an integrated approach to health policies and mental health promotion? These are the main issues addressed in this paper.

Pathologies of Power, Structural Violence and Mental Health

The concept of structural violence, referring to violence that is 'exerted systematically, [...] is intended to inform the study of the social machinery of oppression' (Farmer 2004: 307). It suggests that violence is structural in two ways.

Firstly, social inequalities based on race, gender, class and ethnicity are structured so that individual behaviour choices are circumscribed and structurally limited and conditioned. Secondly, inequality in terms of exposure to risk and access to health care also constitutes a form of violence. In Arachu Castro's (2006) words, 'in contrast to direct violence in which the perpetrator is apparent, structures of inequality and their architects are often rendered invisible through normalized discourses of blame that implicate the poor as responsible for their own dilemmas. As an analytical tool, structural violence redirects our attention away from the presumed pathologies of the subaltern and refocuses our interest on those in power'. According to Farmer's analysis of AIDS in Haiti, structural violence also refers to 'a broad rubric that includes a host of offensives against human dignity; extreme and relative poverty, social inequalities ranging from racism to gender inequality, and more spectacular kinds of violence in the undeniable form of human rights abuses' (Farmer, 2003: 8). Given such a perspective, research should be directed towards a denunciation of the structural causes of disease rather than solely analysing the influence of local culture on interpretations of illness or traditional healing practices.

In regards to mental health issues in the French Caribbean, questions arise concerning the relative importance of economic, political and cultural levels of structural violence and the interactions between them. Firstly, it is possible that structural violence may also be cultural, as expressed through the identity crisis in French neo-colonial Martinique. Depression can be seen as a pathology of power in a post-colonial context. Many years of fieldwork confirm, however, that beliefs in *quimboiserie* (local witchcraft) and its practices, local idioms of distress, religious discourse concerning responsibility and the cultural construction of chauvinistic gender-relationships are examples of fundamental cultural mediators of the impact of structural, post-colonial violence on health.

Secondly, Martinique and Guadeloupe, with their comparative wealth, greater resources and healthcare opportunities, challenge the easy equation between poverty and distress. Why do these neo-colonial Caribbean societies combine very high standards of living and public biomedical services with such a high prevalence of mental distress and suffering? Local political and sociological discourse explains this apparent paradox by describing the pathogenic post(neo)colonial society as a *société krazé* (oppressed society). Political subordination and economic dependency on France are seen as structural causes of psychological distress.

Mental Health and Psychological Distress in Martinique

Epidemiological indicators and local medical discourse suggest that Martinique shows a high level of psychological distress and a great prevalence of mood disorders. The portrait based on epidemiological data shows that mood disorders, and depression in particular, are currently on the rise in the French Antilles. In 2000, 13% of the population over 18 years of age suffered from moderate symptoms of depression; 11% presented symptoms of 'generalized anxiety'.¹ In 2004, one third of teenagers reported significant symptoms of depression.² In the mid-nineties, mental disorders accounted for 35% of all hospitalizations for men aged between 15 and 34. Though the prevalence of suicide in Martinique is still lower than the rate in France, suicide, which was almost absent in traditional Martinique, is now appearing as a striking new phenomenon. Finally, between 1990 and 2000, the number of drug addicts under the care of the health system doubled. Incidences of psychotic disorders induced by crack cocaine are a matter of growing concern for health officials. This epidemiological portrait is confirmed by daily clinical practice. The interviews I have conducted over the past twelve years with 55 physicians and psychiatrists show that, based on their clinical experience, depression and

anxiety disorders have become the main health problem in Martinique in the past two decades and that they reflect deep, severe and 'generalized' mental and social suffering. In spite of easy access to specialist and free health care, an exceptional quality of life as well as the highest standards of living and the best social security policies in the Caribbean, these mental disorders and suffering are seen by health professionals as a real epidemic and one of the major challenges for these societies that are undergoing radical change. Given this situation, the question arises as to whether economic structural violence is solely responsible for the mental suffering and mood disorders. Physicians and intellectuals alike tend to explain the situation through other kinds of structural violence, such as a deep structural identity crisis (Martinicans feel neither French, European nor Caribbean), destructuring of traditional gender roles and a feeling of vulnerability stemming from the fragility and artificial nature of the local standard of living.

Towards a Third Approach to the Analysis of Mental Suffering in the French Caribbean

In many publications, anthropologists (Bibeau, 1996; Singer and Baer, 1955; Farmer, 1992 [1996] among others) have tried to implement a multi-dimensional approach to the illness experience. In his introduction in a 2001 issue of the *Medical Anthropology Quarterly*, Peter Guarnaccia makes a plea for a 'third moment' between cultural constructivism (the ways in which meanings shape our understanding and experience of the world) and a social-structural perspective (the ways in which social realities shape health and illness) (Guarnaccia, 2001). Although objective structures independent of the consciousness and desires of agents exist and are capable of guiding or constraining their practices or representations, there also exists a social genesis of patterns of perception, thought and

action. This third moment in medical anthropology should not consist of a pseudo-synthesis that simply involves the layering of potentially relevant influences on health into ever-larger models. In the words of Dressler, 'This is a synthesis of two quite different views of human social life, [that....] by its very nature forces us to take the intersection of cultural construction and structural constraint seriously' (Dressler, 2001: 457).

However, although many authors recognize the theoretical importance of combining different levels of interpretative and critical analysis, this objective is not always attained in medical anthropology publications. Such a challenge is, and must remain, at the very heart of anthropology (and perhaps all social sciences). Must anthropologists surrender to this challenge and concede the incommensurability of these levels of analysis? Or must this combination be made one of the conditions for the evolution of medical anthropology and the discipline as a whole? I agree with Jean and John Comaroff who call for 'an historical anthropology that tries to dissolve the division between synchrony and diachrony, ethnography and historiography; that refuses to separate culture from political economy, insisting instead on the simultaneity of the meaningful and the material in all things' (Comaroff and Comaroff, 1993: 19). Indeed, medical anthropology has no other choice but to accept this challenge. To confine oneself to the analysis of cultural representations of health is to condemn oneself to the marginal status of a cultural fact specialist and to being labelled as a specialist in 'exotics'. Conversely, by exclusively embracing a political economy of health, one is condemned to macro-political explanation without the expertise of the *-emic* analysis of illness interpretations and experiences.

My research in the French Caribbean is in line with this composite point of view. Indeed, my position is that a medical anthropology of mental and social suffering should consider the complex ramifications of three fundamental dimensions of social suffering: (1) structural,

economic, political and cultural predisposing factors: in the present case, neo-colonial structural violence as expressed through economic dependency and political subordination as well as an identity crisis; (2) intermediate socio-cultural factors (underemployment, migration, gender conflict) that are conditioned by cultural values and structural factors alike; (3) a local language of distress based on local idioms of identification, interpretation and explanation of illness and suffering. The point I wish to make here is that the pressure on mental suffering represented by the two first macro and meso levels of distress causation is also mediated by local idioms of distress and other influences of culture on ill-being. The originality of anthropology, as well as its contributions to health policies, resides in a methodological and theoretical ability to combine these critical and interpretive approaches.

Structural Violence, Neo-colonialism and Mental Suffering

Martinique is a post-colonial society that remains profoundly marked by its colonial history, as can be seen in its political structures, economic dependency, cultural identity and even social relationships and patterns of culture. Even today, it is largely influenced by political and economic structural factors that circuitously exert strong pressure on the psychological well-being of the people.

At the political level, the 1948 'departmentalization' is considered by local economists and sociologists as a consecration of the political dependency of Martinique on France and subsequently on European institutions. Martinique's new status as a French overseas *département* would have confirmed nothing but a new form of neo-colonialism. Colonialism has changed its face but not its goals. From an economic standpoint, the new political status has likewise confirmed the economic dependency of the island. Sugar production has decreased to a small fraction of what it was in the early

1950s. The banana industry is declining. Given the high production costs and an inability to compete with African and Latin American production, this dying agriculture continues to survive only as a result of massive investment by the European Economic Community. Some have described this situation as a political construct of dependency (Leotin 1997; Daniel 1997). According to Leotin (1997), it is 'false development' based on 'transfer payments' from France and on a tertiary economy. Raphaël Confiant points to the 'improduction methods', involving an economic system based on very low production and very high consumption that produced an import-export exchange/coverage rate of 15.9% in 2004 as the fundamental cause of the Martinican identity crisis (Confiant, 2006).

Political subordination and economic dependency have led to structural vulnerability and a deep feeling of incompetence. As such, they are not the direct causes of mental suffering. The violence does not reside directly in these macrostructures, but rather indirectly in their effect on identity, community pride, self-confidence and on feelings of dispossession, mis-recognition and disempowerment that have acquired a strongly pathogenic character. In such a post-colonial context, mental suffering arises from feelings of uselessness, self-depreciation, deprivation, alienation and vulnerability. This type of 'cultural violence' is just as structural as political or economic violence.

In their attempt to explain the impact of colonialism on mental health, Martinican intellectuals address this deep collective identity crisis in two ways. An initial psychoanalytical discourse characterizes the Martinicans as having a deeply wounded psyche, whereas a second sociological discourse considers Martinique itself as a pathogenic society. In the first psychoanalytical discourse, Creole people are portrayed through such negative concepts as alienation, the colonized mentality, deculturation, and 'internal exile'. These problems lead to a form of 'self-domination' and self-depreci-

ation that are the underlying causes of structural distress (Afferghan, 1983: 31). In the second discourse, Martinican society is seen as disorganized, divested of culture and fundamentally pathogenic. It is characterized by a denial of its history, an absence of collective memory and its corollary, the absence of community projects and any projection into the future (Glissant, 1981: 88). This sociological discourse reviews the impact of a colonial past on social life instead of examining intra-psychic dysfunctions. Martinique is a pathogenic society or, in the vocabulary of Auguste Armet (1990), a '*societe krazé*', crushed by the pressures of oppressive neo-colonial economic and political structure, and characterized by moral misery, sociopathy and a pathological dependency on France. Other authors talk of an economically and politically vulnerable society, whose vulnerability stems from its inability to build sound social links (Ozier-Lafontaine, 1999: 17). In such a neo-colonial context, people would have developed a deep sense of uselessness and superfluity; decisions are made and actions are undertaken outside of this island and individual efforts serve the interests of France instead of local interests. There is a kind of 'pathology of disengagement' towards family, work and civility (Ozier-Lafontaine, 1999). In each of these discourses, structural violence is seen as the cause underlying an identity crisis. Martinicans are neither Africans, Europeans nor French men and women. The Creole language is despised in comparison to French. Even the concept of '*creolité*', developed by some intellectuals, does not succeed in rallying people around the concept of a French-Caribbean identity. This harm to the Martinican identity is much more damaging than economic dependency or political subordination and is probably the most important manifestation of structural violence.

For a fraction of the population, the Creole identity promoted by nationalist intellectuals is a source of pride. For others, it appears to be

an endless quest for cultural affirmation and political recognition as expressed through political movements demanding recognition by France of slavery as a crime against humanity or through demands for reparation for the abuse suffered by slave ancestors (Taubira, 2002). The 'symbolic violence' expressed in the historical refusal of metropolitan France to recognize Martinique's linguistic, cultural and societal specificities is also associated with a 'psychological violence', itself rooted in strong feelings of economic vulnerability, individual social uselessness, political frustration, and resentment towards the colonial past. French Caribbean societies are facing a form of pathology of recognition resulting in deep-rooted bitterness. Mental disorders can be seen, in part, as expression of an embodied colonialism.

Farmer suggested, for Haiti, that the erasure of historical memory and other forms of de-socialisation create conditions for structural violence (Farmer, 2004: 308). In Martinique, structural violence seems, instead, to be rooted in a constantly re-affirmed pathogenic memory integrating the aftermath of colonialism into the cultural identity. It is rooted in an over-socialisation of historical memory and of resentment which appears as internalised cultural violence.

Living Conditions as Intermediate Factors

A second challenge emerges for medical anthropologists. Considered alone, these forms of cultural-structural violence do not have a direct impact on the mental suffering of a people. For a considerable section of the population who are merely trying to make a living for themselves and who stay away from political debates, the effects of structural violence (political, economic or cultural) are mediated by more tangible intermediate factors that have a daily impact on the development of mental and social suffering. In the words of Bourgeois and Schepers-Hughes (2004: 318), critical an-

thropologists 'need to disentangle the causes, meanings, experiences, and consequences of structural violence and show how it operates in real lives [...]'. In Martinique's specific neo-colonial context, a few of these mediating factors are: a) the question of colour and the latent racial tension between whites and blacks that continues to pervade daily social life. Political conflicts and even company strikes are strongly affected by the relationship between employees, most of whom are non-white, and their white managers, French from the mainland or white Creoles (*békés*); b) underemployment (there is a 22% unemployment rate among the general population, rising to 40% among the active population who were under 30 years of age in 2002) is a meso-structural condition conducive to mental suffering. This leads to frustration among young adults who see no professional future ahead of them and it generates stress among parents who continue to house their jobless children well into their thirties; c) marital conflicts affected by the chauvinistic ideology inherited, in part, from slavery. Health professionals unanimously agree with the diagnosis that conflicts between spouses are the major 'intermediate' causes of mood and anxiety disorders and suicide attempts; d) parental distress resulting from the emigration of children; e) rejection felt by migrants returning to Martinique and difficulties experienced in rebuilding social networks after many years of absence spent trying to find work in France; f) social tensions engendered in families by the conversion of traditionally Catholic Martinicans to the new Protestant churches with their numerous social prohibitions and exhortations.

As can be seen in tens of case studies of depression narratives and biographies that we collected through fieldwork, mental suffering cannot be understood from an anthropological standpoint without an in-depth analysis of the day-to-day social construct of distress, frustration, anxiety, stress and suffering resulting from such concrete conditions of existence. These conditions themselves cannot be fully understood

without reference to the historically grounded political and economic structures that have engendered them. The analysis of the complex influences of political, economical and cultural-structural violence on the daily conditions of life is a major challenge for a comprehensive, multi-dimensional approach to medical anthropology.

Idioms of Distress in Martinique

Finally, there is a third level of analysis that is more traditional for the anthropologist, that of local idioms of physical, verbal, emotional and behavioural distress as culturally accepted modes for expressing mental anguish. These idioms are inter-subjective abstractions that condense and transform idiosyncratic experiences of suffering into culture-specific concepts. They act at three levels: (1) the way people name their episodes of life experiences (idioms of categorization); (2) as cultural forms that guide the way people experience and communicate their distress physically and emotionally (idioms of expression); and (3) the way they make sense of these experiences (idioms of explanation) and identify the plausible causes thereof. The multiple latent combinations of these idioms constitute a group's language of distress (Massé, 1999). An analysis of these local idioms has been presented elsewhere (Massé, 2001). However, to illustrate the relevance of combining structural and cultural analyses, let me briefly discuss three idioms of explanation.

Though some of the leading local idioms of expression of mental suffering are somatisation, persecution delirium, auditory hallucinations and physical aggression, in such a neo-colonial context, 'lack of responsibility' expressed through the Creole concept of *yo* emerges as one of the core idioms for explaining and interpreting suffering. In creole, *yo* (them) is a core concept used to shift the blame for what happens to an individual towards someone else: '*Yo fè moin mal*' (They [someone] hurt me). 'I am not responsible for what happened to me. The mental disorders and social suffering are the

fault of a neighbour, a member of my family or a jealous colleague who set *quimbois* (sorcery) on me'. The systematic transfer of responsibility to *yo* and its deep-rooted effect on help-seeking behaviour, especially when resorting to traditional healers (*quimboiseurs* and *gadè zafè*), should be understood, at least partly, in reference to the pathologies of dependence and recognition. These pathologies, which are associated with the Martinican's problematic relationship with accountability, are themselves caused by neo-colonial political and economic structures.

A second, related idiom, *devein*, is a form of chronic bad luck that follows an individual for a long period of his or her life and becomes a specific underlying logic of unhappiness. It refers to a chronic fatalism that requires the intervention of an external, supernatural force responsible for the series of misfortunes. *Devein* is almost systematically interpreted as the work or *travay* of 'someone who wants to harm you', usually out of envy or jealousy. These idioms are related to a third core idiom explaining suffering known as *quimbois* or bewitchment. It refers to a magic or evil spell cast on a victim, to the object (i.e. miniature casket, piece of clothing) that serves as the medium for the spell as well as to the evil spirits sent by a *quimboiseur* mandated to do evil. It can be hypothesized that these three explanations of the idioms of distress only make sense in a global context where Martinicans seek the root of any misfortune in supernatural forces but also in a political disappropriation of responsibility on the local scene. A third and probably the most complex challenge for medical anthropology resides in the analysis of the dialectical relations between these three elements, namely local interpretations of distress, concrete conditions of existence and the weight of the neo-colonial structures of violence. What does it mean to speak of dialectical relations between (a) cultural idioms that transfer the responsibility for misfortunes on to *yo*, *quimbois* and *devein*; (b) the social construct of suffering grounded in intermediate socially and economically induced

gender, marital, intra-familial, racial or inter-generational conflictual relationships; and (c) macro-political and economical structures of dependency on the French mainland?

Pitfalls Associated with an Exclusive Focus on Structural Violence

This brief analysis of the interrelation between multiple layers of meaning and causal explanation of social and mental suffering illustrates the importance of a comprehensive approach to medical anthropology. An exclusive focus on a macro-analysis of the effects of international policies on the causes and treatments of health problems could lead our discipline towards the following pitfalls.

Conceptual Imperialism

Structural violence, from the standpoint of a meta-narrative on the cause of illness, raises the question of an unnecessarily restrictive explanation of the meaning of illness by imposing an analytical grid (concepts, theories) that is foreign to local realities. How can we achieve this complementarity of approach without falling into the trap of a reductionist understanding of the role of structural conditions, and of a delegitimisation of lay dialogue (Kleinman, 1994)? Indeed, there is a risk that the concept of the pathologies of power and the search for political meaning might supersede any inter-subjective and situational meanings of the experience of suffering. Depression in Martinique is not reducible to a pathology of post-colonialism. In Kleinman's words, 'the interpretive requirements of suffering for theodicy—namely, the struggle to reconstruct a coherent account of why poverty exists in the world—are viewed by many anthropologists as the core reality of suffering. [But] the inter-subjective experience of suffering is so varied, so multilevelled, so open to original inventions, that interpreting it solely as an existential quest for meaning, or as

a disguised popular critique of dominant ideology, notwithstanding the moral resonance of these foci, is inadequate. It may distort this most deeply human condition' (Kleinman 2000: 145).

The danger associated with theoretical meta-narratives of the pathologies of power lies in the subordination of ethnographic data to an interpretation 'guided by a pre-given meta-narrative, rather than close attention to the interaction between the ethnographer and his or her interlocutors in the production of anthropological knowledge' (Englund and Leach 2000: 236). It could also be to 'contribute to locating all effective historical agency or causation in metaphysically conceived wider forces' (Sangren 2000: 243). Medical anthropology must therefore be careful not to overuse concepts and meta-narratives that simplify the complexity of illness experienced and do violence to the situationally particular. Medical anthropology should not only teach anthropologists and health professionals how to consider mental disorders by providing them with analytical grids of suffering. Nor should it teach researchers how to think for themselves (for example, as agents who help change structural determinants). Medical anthropologists must, firstly, use their practice to learn to think from lived distress, fully respecting the multiple layers of the contexts that explain and give meaning to suffering.

The Risk of a Disqualification of the Locale

In this day and age, anthropologists no longer treat the locale as a geographically circumscribed space in which meanings are created, in which the most important social interactions occur, in which economic and affective life is lived, and in which social structures are reproduced. A vigorous defence of a return to what is unique in the ethnographic method is required, *i.e.* a reflexivity that gives subjects authority in determining the contexts of their beliefs and practices. If we do not do so, we are

greatly at risk of discrediting the locale, replacing it with an asymmetric power relationship analysis associated with globalisation and essentialised structural violence. Moreover, we should be justifiably afraid that an exclusive focus on the meta-narratives of structural violence provides anthropologists, especially young inexperienced researchers, with ready-made constructs concerning the broader and the local context. Ethnography must not become attuned to the locale through theoretical predetermination. The challenge, as stated by Bourgeois and Schepher-Hughes (2004: 318), is to specify empirically while theorising broadly on the ways in which everyday life is shaped by historical processes and the contemporary politics of the global political economy. As Appadurai (1996) so aptly noted, the fundamental question here is the following: does the larger-scale perspective yield more knowledge about the narrower context than a focus on the local context itself? I believe, along with Abeles (1996), that anthropology must be careful when faced with the fetishist trap of microanalysis and the illusion that proximity generates, quasi-mechanically, a better knowledge of the object (Abeles, 1996). Indeed, deconstruction of macro-analytic categories could condemn us to an epistemological powerlessness. Conversely, resorting to macro-analytical approaches and reified models and concepts may be responsible for oversimplifications that have heavy ideological, and even political, consequences. If anthropology is not deeply anchored in fieldwork, it is at risk of becoming disengaged from reflexive knowledge production.

The Drift toward Causation and the Moralisation of Research Goals

There is a moral imperative for anthropologists in the structural violence approach. It is that of a revitalisation of what Heggenhougen (2004) called a 'therapeutic anthropology' dedicated to a social therapy of inequities, to the

identification of 'sinful' conditions in need of correction and to a clarification of the social machinery that reproduces structural violence. I believe that one of the key questions could be the following: should medical anthropology be concerned solely with the causes of diseases and suffering? Or is there still room for social scientists concerned about the work of culture on the interpretation of disease, aetiology or healing practices?

It seems to be clearly established (including among cultural anthropologists) that cultural factors may only partially contribute to causation models. In the case of mood and anxiety disorders in Martinique, local idioms of distress and practices of *quimbois* have, in themselves, little to contribute to an explanation of the explosion of cases of depression, suicide and drug addiction. Heggenhougen (2000: 1171) perceptively states that 'while cultural factors are crucial, a major role for anthropology [...] is also to direct our focus to the total context of people's lives, to the wider "social roots of disease"—and particularly to the deleterious elements in most societies of violence, inequity, and marginalization'. However, medical anthropology must go beyond the building of concepts and theories to be used in the analysis of illness and suffering causation and encompass the analysis of the multiple layers of significance of suffering.

From an anthropological perspective, illness and suffering cannot be reduced to their dimension of 'pathologies of power', even if it can be clearly seen that social, political and economic inequalities explain many modern 'epidemics'. Mental health problems, in particular, call for more complex causal analysis; Martinique provides a compelling example. Poverty is much less of a cause than the artificial nature of the standard of living and the consequential feeling of vulnerability and dispossession. In Martinique, it is culture that still defines disorder categories, local aetiology, idioms of distress and the frontiers between body and mind, emotion and cognition. Medical anthropology is right in

denouncing a culturalist drift that eventually produces 'symbolic violence' (Fassin, 2001) and that interferes with an analysis of the structural, economic and political causes of suffering. The discipline must nonetheless avoid any sidestepping that would reject studies of the influence of culture on illness related behaviour. It may therefore be right to state that, 'the divorce of research and analysis from pragmatic efforts to remediate inequalities of access is a tactical and moral error'. (Farmer 2003: 22). Nor should it be claimed that the emphasis on both structure and violence in producing health inequalities must necessarily shift our gaze beyond policy to politics, beyond history to political economy (Singer and Castro 2004). The primary challenge, however, is to merge these approaches and to continue to nourish them with in-depth ethnographic fieldwork. That is a prerequisite for any applied medical anthropology.

Conclusion

I believe that it is becoming newly urgent to understand the ways in which the global meets the local in the creation and explanation of illness (McGrath, 2006). Yet I remain wary about the dilemma that medical anthropologists are facing, which forces them to choose between an anthropology dedicated to the denunciation of structural violence or one that restricts itself to analysing the semantic networks of illness. Can we not devise a medical anthropology which sees all of these phenomena as legitimate, relevant subjects of research? 'Must we', as Fainzang (2005) asks, 'make a permanent choice between culture and politics? The contributions of a comprehensive approach is illustrated in the study of mental suffering in Martinique. Mood and anxiety disorders, as well as local idioms of distress, are profoundly rooted in malaise linked to social conflicts, magico-religious beliefs, a neo-colonial social construct of responsibility and a crisis of vulnerability and recognition. These forms of malaise cannot be understood

without referring to a structural identity crisis that is rooted in the pathology of recognition which is itself reinforced by a neo-colonial interaction involving economic dependence and political subordination to France and the European Economic Community.

Social suffering and psychological distress in the French Caribbean illustrates the complexity of the impact of structural violence. Local interpretations through idioms such as *quimbois*, *devein*, or *yo* stem from an ethic based on the transfer of responsibilities for individual misfortune to external forces. Local discourse on the *société krazé* and the pathologies of recognition, dependence and vulnerability draw on a moral discourse concerning the fate of postcolonial structural violence. Nonetheless, seeing these malaises as expressions of the pathology of power and neo-colonial ethical issues should not prevent anthropologists from addressing the context and local construction of the human moral experience. What matters most, according to Kleinman (2006), is a profound change in moral life, a transformation that is not simply a consequence of the large scale, disruptive, historic forces of politics and political economy, but also a result of the interaction between cultural meanings, social experience and subjectivity. The meaning of the interactions between these multiple layers of suffering, which is the ultimate quest of anthropology, can only be found through their in-depth analysis based on fieldwork.

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Notes

1. Bulletin Flash of the Observatoire de la santé de la Martinique, No. 27, October 2001. Survey conducted using the MINI diagnostic questionnaire.
2. See Bulletin No. 35 published by the Observatoire de la santé de la Martinique

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