

Introduction: Sensations, Symptoms and Healthcare Seeking

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Inspired by the sensory turn in the humanities, anthropologists have coined the term ‘an anthropology of the senses’ to describe the study of the perceptual construction and output of bodily sensations and sense-modalities (cf. Howes 2006; Nichter 2008). Starting from the premise that different cultures and social settings configure, elaborate and extend the senses in different directions, key proponents have argued for a greater empirical and analytical attention to the cultural embeddedness and socio-biological basis of bodily perception and experience. This follows a rethinking of a series of theoretical (cf. Hinton et al. 2008; Ingold 2011) and methodological commitments in anthropology (cf. Pink 2009; Stoller 2004) that also holds relevance for anthropological studies of health and illness, which is the focus of this special issue on sensations, symptoms and healthcare seeking.

Other excellent work has traced the emergence of an anthropological focus on the senses (e.g. Herzfeld 2001). What follows in this introduction is therefore not intended to be a comprehensive overview. Rather, with a view to human suffering and what Thomas Csordas has called somatic modes of attention (1993) related to illness, sickness and disease, we wish to illustrate some of the links or contributions we see an anthropology of the senses may have for what has been referred to as ‘medical anthropology of sensations’ (Nichter 2008), and in particular its dealings with ‘symptom experiences’ (Hay 2008). As aptly phrased by Herzfeld when delineating an anthropology of the senses, the issue in medical anthropology ‘is no longer simply one of recognizing that culture mediates experience but has become a focus on how such mediation is negotiated and modulated through actual changes in the social sphere’ (Herzfeld 2007: 433). The anthropological work on the senses originates from a critique of functionalism in studies of religion and ritual and its neglect of a lived bodily experience, and

from a critique of Western occularcentrism and the universality of five senses modalities (Porcello et al. 2010). Porcello and colleagues (2010) thus identify the development of three different genealogies as reactions to these critiques and assumptions. First, following especially Howes (2006) and Classen (1997), the senses are seen as already fully cultural, senses are not pre-cultural or transparent but are embodied experiences in culturally recognisable forms (Herzfeld 2007), and sensory perception is a cultural as well as a physical act. Our senses make up a sensorium that is historically and socially constituted, and is a fundamental domain for cultural expression and communication, making a sensory approach possible to link to, for example, analyses of formations of self, social organisation, symbolic value systems, cultural ideologies, local biologies and the politics of perception. Drawing forward the sensorium and an emphasis on bodily sensory models is coupled with a critique of anthropology's detour to discourse and text and with a critique of universalising subjective sensations.

Secondly, ethnographies of the senses in other cultures challenge the rigid Western understanding of the five senses and call for what Stoller initially referred to as 'sensuous scholarship' (cf. Stoller 1997, 2004). Knowledge is not only verbal or linguistic but held in multisensory experience; senses mediate the worlds of the material, social and spiritual, and anthropologists should attend to the sensory world of others as well as their own to get to the phenomenology of the fieldwork encounter and its knowledge production (Ingold 2000). This insight also came to Geurts (2002) during her fieldwork among the Anlo of southeastern Ghana, whose sensorium, or pattern of importance and differentiation of the senses, places high value on balance and posture, in both a literal and metaphorical sense. The 'five senses' model, she argued, is undoubtedly arbitrary in comparison with medical evidence; more importantly, it is neither the only nor the most reasonable model of perception. The principal argument of *Culture and the Senses* (2002) was rather that sense systems vary according to

cultural traditions, and that these systems of classifying and ranking senses encode moral values in the process of child socialisation, inscribing them upon the body through the formation of habitual practice. Geurts aptly showed how the sensorium functions in Anlo society to shape notions of personhood, and, by extension, the experience of health and illness.

Arguing for more ‘sensuous scholarship’ along the same line, Pink, drawing on her work on design and engineering has engaged specifically in discussions on the methodological commitments she sees as following an enhanced focus on the senses (Pink 2009). In other words, ‘sensory ethnography’ according to Pink may be characterised by an interdisciplinary scholarship calling for studies on practice and theory while sharing ‘sensuous’ research methods and theories of sensory perception (ibid.).

Thirdly, it has been argued that significant relations exist between technology, perception, the everyday and the sensorium (Seremetakis 1994). In other words, senses connect with memory and cultural, material artefacts, and they are a site for recovering the memory of culture embedded in personal recollections and material artefacts (ibid.). This way of reintegrating the sensorial with the material, of constituting the social unconscious as an integrated sense experience, and of pointing to a construction of meaning and truth through sensorial experience different than through language, is an anthropology of the senses that connects to the material world and history in an evocative mode different from discerning symbolic codes of sensations or being a sensuous scholar.

The anthropology of the senses is thus not a unified ‘turn’. It springs from diverse theoretical genealogies and from central discussions in anthropology at large, developing arguments, theories and scopes along the way. Basically, however, the senses are considered a novel entry to understanding culture and constructing knowledge, but still, even though we may have conveyed a brief overview, something is amiss probably to the reader as much as to

us, something which is not quite clear and explicit in this introduction: How are we, with a medical anthropological approach, to understand senses? What do we talk about when bringing senses to the fore? Do they constitute a bodily language, ways of expression and communication? Or are the senses embodied symbolic representations of culture, that is a statement reifying culture building on a representational theory of knowledge, as Howes et al. (2014) argue? Or is sensorial experience, as Ingold has also argued, always a nexus of perception and action, at the same time practices performed, modulated and mediated (Ingold 2011)? Several such issues are central and a matter of debate, and in our view leading to an emphasis on the understanding of senses as embodied cultural constructions, constitutive of social interaction and cultural meaning. Such reflections also lead to a question of whether we study actual senses – whatever they may be defined as – or whether we study sense modalities as an entry to understand culture and society. Inherent in such discussions is on one hand the departure and dismissal of language and discourse to the advantage of bodily knowledge that to some scholars represents the fundamental and presumably only key to culture analysis. Others, on the other hand, argue that discourse is ‘part and parcel of processes of embodiment and knowledge and sense-making’ making it irrelevant to dichotomise bodily sensorial knowledge and linguistic expression (Porcello et al. 2010). Consider, for example, discussions brought forward by Bourdieu on the intricate relations between class, taste and embodiment in his work on social class in France, and which has been reproduced in other social settings. Pathak (2015), for example, shows how the embodiment of emergent consumer identities in Urban India guides perception and affection and thus feeds into the sensuous experiences of fashion and beauty. In other words, and supporting our own approach, senses and language or discourse work together and do not exist independently of each other.

Within the anthropology of the senses certain of the genealogies above have inspired medical anthropology more than others. Especially the concept of the sensorium and its emphasis on bodily experience and knowledge constructing both culture and social relations has influenced the creation of a 'medical anthropology of sensations'. In a special issue of *Transcultural Psychiatry* several researchers embarked on presenting an agenda for this to explore the relevance of the senses to medical anthropology (Hinton et al. 2008). This agenda was primarily based on an investigation and definition of what are bodily *sensations*: How may we speak of sensations such as dizziness, pain, itching or fatigue and how are sensations generated and amplified as well as producing meaning within a combination of processes such as for example attention, physiology, imagination, metaphors and self-image (Hinton et al. 2008). In other words, the authors argue that any sensation is produced and altered in a process of attention and interpretation, and of specific interest to medical anthropology are then the sensations that are felt and experienced as part of or prior to a period of suffering, or to explore how sensations become filtered through an idiom of distress (Nichter 2008). This, in the words of Nichter, implies studies of 'how different cultural settings in which bodies are situated predispose or construct perceptions of sensations associated with wellbeing or disease' (ibid.: 164). The agenda for a medical anthropology of sensations then becomes one of understanding such bodily sensations as culturally embedded, and to explore their production, their meaning-base, their configuration in a social and political context of health as well as always attending to their biological and physiological basis – while at the same time paying attention to the transformation of sensations into symptoms. With the words by Hay (2008: 221) this understanding may be epitomised as:

A sensation is embodied; it is felt experience. By contrast, a symptom is a constructed and socially informed cognitive interpretation that indexes but is not itself an embodied sensation.

Although it is clear that a medical anthropology of sensations bears on the above genealogies, especially the one on cultural expression and communication, also much ‘sensorial/sensory anthropology’ and its approach to sense and sensing involves to a high degree the interaction between the anthropologist and her/his interlocutors in the process of knowledge production. This means to emphasise interaction that plays out the use of senses for both parts using for example visual methods or deploying sense experiences as methodological tools. ‘Sensorial anthropology’, however, according to Nichter (2008) also covers all the studies of cultural responses to sense modalities and sensations, including the study of bodies and sensations associated with vulnerability, fear and suffering:

Sensorial anthropology explores how sensations are experienced phenomenologically, interpreted culturally, and responded to socially. (ibid.: 166)

To deploy such an exploration, medical anthropology of sensations primarily takes the body to the centre stage and seeks knowledge of that body’s sensations and especially of the sensations that belong to or get to belong to the realm of health and suffering. In other words, what medical anthropology looks for and takes a special interest in is a subtle relationship between sensations and symptoms, but not only the relationship, also the process of transformation, the experience of turning sensations into symptoms. Some sensations are transformed and become symptoms and some do not, and their specific transformation depends on the context that modulates and mediates the configuration of symptoms. With

inspiration from Ingold (2000) this involves a notion of senses and sensations as existing in a field of relations, a field where the dichotomy between the individual and the social is dissolved.

At a conceptual level, what characterises the articles in this issue is that they encourage a critical engagement with dominant approaches to the exploration of symptom experiences within medical anthropology. Anthropologists have long been interested in the ways societies recognise and categorise symptoms. But a theoretical departure in a medical anthropology of sensations provides for more clarification on how symptom experiences evolve in cycles of bio-social interpretation involving both individual and shared cultural templates. Instead of simply asking how meaning and significance is attributed to symptom experiences, it asks how embodied sensations are evoked and become endowed with significance as symptoms in the first place and how shared cultural templates on ‘what counts as symptoms’ evolve, mediate and feed into this process (Lock 1993; Nichter 2008). As we have suggested elsewhere, this may revive ‘symptoms’ as a powerful analytic trope for the exploration of the interface between biomedicine and society and for tracing how social change adds to the building of disease sensibilities in diverse social settings (Andersen, in press; Eriksen and Risør 2014). As stated by Andersen (in press), studies of symptom categories may find inspiration in critical approaches to the study of diagnostic categories as deep seated, cultural assumptions about what it means to know the body in the context of (bio)medicine (cf. Young 1997), and how they open up new spaces for the articulation of distress (cf. Nichter 2010: 404).

The articles empirically draw on different social and cultural arenas. This provides us with – if not strictly comparatively generated insights – glimpses into how different social, cultural and institutional settings configure, elaborate or organise bodily experiences differently. The articles presented by Offersen and Merrild and their colleagues both explore

how embodied sensations are articulated and experienced within the confines of the Danish welfare state, but examining different social groups. These studies aptly illustrate how embodiments of social class configure into different forms of sensation experiences and modes of articulation. Offersen, basing her work on the Danish middle class, argues that embodied experiences and sensations are articulated and given meaning in a moral sensescapescape of being a good citizen. Being a good citizen both requires taking good care of one's health (see the doctor when relevant) and not misusing common goods (do not misuse doctor and healthcare system resources), and thus constitute complex navigational routes when deciding when 'something' should be considered a symptom of disease that warrants medical assistance. Drawing on theoretical reflections on local biology (Lock 1993) and comparative work on the upper middle class and the lower working class in Denmark, Merrild is able to show how sensorial experiences are tied to particular social situations, and how the transformation of sensations into symptoms is configured in relations between diverse forms of social suffering and local biologies. People from lower social classes, she argues, have 'noisy bodies', providing a particular point of departure for translating embodied sensations into 'symptoms' and not least for responding to and articulating them. Merrild thus extends Lock's critique of biomedical notions of 'the universal body' present in clinical research into reflections of the universal body present in public health rhetoric on awareness campaigns and so on.

Based on ethnographic work on trauma and HIV in Uganda, Meinert and Reynolds Whyte also explore the body in everyday life settings. Unfolding Nichter's ideas of dyadic sensing (2008), they show that the sensing body is a 'social body' where the family, a couple, or a wider social network, may be seen as a sensing unit that transcends the individual body. More specifically, Meinert and Reynolds Whyte show us how embodied sensations – which often present themselves as chaotic and ambiguous in 'an individual biological body' – are

often sensed, organised, articulated and managed through social processes and encounters. Overall, they extend ongoing critical reflections on individualised, cognitive perspectives on our understanding on the nature of symptom experiences.

The remaining three articles draw on studies on how people sense or experience sensations as symptoms (or not) when living with a diagnosis; in this case cancer diagnosis. Two articles explore the social settings that structure embodied forms of attention and experience among Norwegian cancer patients. Inspired by Ingold's writings on 'landscapes' and ethnographic fieldwork in Northern Norway, Skowronski and colleagues take us outdoors in the Norwegian Finnmark and illustrate how living in the aftermath of a cancer disease is modified and managed by engagement with what they call familiar landscapes. By conducting old routines in familiar landscapes, the participants experience a significant sense of healing which helps them to alleviate pain and fear and to protect themselves from upcoming illness. The second article from Norway also explores how people manage to live with a cancerous body. Contributing to writings on sensation scripts, Seppola-Edwardsen and colleagues point to temporal aspects of bodily experiences, and aptly illustrate how the articulation and organisation of sensations change over time. Based on prolonged ethnographic fieldwork among 'cancer survivors' in a suburban environment, the article shows how scripts used to frame and organise 'unpleasant sensations' gradually change from being 'alarming and help-oriented' to an emphasis on 'this is probably nothing, it will go away'. Both articles from Norway thus illustrate how the brute existential facticity of having lived with and through a cancer disease both feed into the management of bodily changes or pains as well as its organisation and articulation, showing how individual, temporal and collective ideas of bodily management conjoin in the transformation of sensations into symptoms. The last article fittingly illustrates the relevance of research on sensations and symptoms for medical research or thinking. Departing from a large amount of interview

material with women living in Germany, and who have recently undergone treatment for ovarian cancer, Brandner and colleagues reflect on how to explore a ‘delay in healthcare seeking’. They take a critical stance to explanations of delay and draw on a notion of causality as both process-oriented and contextual, showing how ovarian cancer patients in their healthcare-seeking decisions depend more on specific socio-cultural and moral contexts than on the first disease-related symptom. The negotiation of symptoms is a social process and needs social legitimation (Risør 2011) but, even more, Brander et al. show what lies beyond the symptom. Thus, their contribution is an important attempt to conceptualise delay, talking within the framework and policies of symptom awareness but explicitly pointing to the role of social and moral norms, social positioning and notions of responsibility as decisive to understanding delay and healthcare-seeking.

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