RECIIS – R. Eletr. de Com. Inf. Inov. Saúde. Rio de Janeiro, v5, n.4, p.3-13, Dec., 2011
[www.reciis.icict.fiocruz.br] e-ISSN 1981-6278

* Original Article

Social suffering and the embodiment of the world: contributions from anthropology [1]

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DOI:10.3395/reciis.v5i4.552en

Abstract
Suffering, a complex and multifaceted process that has been debated across different areas of knowledge, is an experience that has accompanied man since his earliest existence. This article aims to introduce the contribution of anthropology to this debate, focusing on the social dimension of the affliction, which has been called, more specifically, social suffering. Starting with an exposition of concepts relating to health problems, it is suggested here that suffering is *social*, not just because it is caused by or occurs in specific social conditions, but because, as a whole, it is an embodied social process in historical subjects. The paper is based on an ethnographic case of the indigenous people of Rio Grande do Sul, in southern Brazil, and discusses three aspects of social suffering: (1) the authorized or contested appropriations of collective suffering, (2) the medicalization of life and (3) suffering in relation to public policies. Finally, the difference between the recognition of a *health problem* and a *process of social suffering* is highlighted, the latter being characterized by the inseparability of physical, psychological, moral and social dimensions of discomfort. It should be emphasized that the contributions of anthropology include the provision of theoretical and methodological tools that allow us to ask, by engaging with the subjects and considering their history and social situation, how suffering is produced and recognized and the political and ethical implications of these different types of recognition.

Keywords: Social suffering; embodiment; anthropology of body and health; medical anthropology; indigenous populations; Brazil

Introduction

Suffering, a complex and multifaceted process debated in different areas of knowledge, is an experience that has accompanied man since his earliest existence. The challenges are enormous, both individually and collectively, in the confrontation of pain and tribulations. These challenges afflict the world in several ways that defy the normal means we have for understanding and conceptualizing disturbances.

Biomedicine (that is, Western scientific medicine) and its related fields have offered some of the most recognized approaches to developing ways to relieve suffering, including various forms of treatment of pain and discomfort. In so-called complementary or alternative medicines, which also represent knowledge that is widely used in the relief of suffering and pain, many approaches incorporate traditional knowledge, and others develop new approaches.

With its focus on another dimension of illness, the internal and subjective processes of individuals without disregarding somatic symptoms, psychology has also provided important contributions to the study and treatment of suffering. Social psychology approaches suffering from a different perspective, emphasizing the intrinsic social dimensions of suffering and conditions related to the living conditions of individuals in societies. Thus, some studies in this area consider the social conditions implicit in the construction of individual subjectivity. Feelings such as humiliation, shame, fear and guilt and the effects of experiences in specific social conditions can be seen as violent forms of suffering, with causes and consequences related to a shared social environment (CARRETEIRO, 2003). In this context, this area converges with the anthropological view of social suffering, which according to Kleinman et al. can be described as the result of " the devastating injuries that social force can inflict on human experience" (KLEINMAN et al., 1977, p.ix). [2]

This article aims to explore what has become known as "social suffering" from the perspective of anthropology. I do not therefore attempt to prioritize knowledge and actions focused on understanding and/or relieving human suffering but instead attempt to present an approach that

fundamentally values the socio-cultural dimensions of suffering. This approach also implies that suffering is a condition that resists the separation of physical, psychological, mental and spiritual dimensions. The recognition of this inseparability of spheres of life in studying social suffering is exemplified by Kleinman et al.'s argument that when focusing on human problems, one must be concerned with the "moral, cultural and political nexus" in which they are processed (KLEINMAN et al., 1997, P. xxv). Thus, the anthropological approach to this phenomenon fundamentally returns to social, political, cultural and economic processes, which combine to produce embodied forms of suffering, and explores how these forms also contribute to the specificity of social life. The anthropological approach encompasses the tension inherent in the dichotomy of society versus the individual, in that suffering implies multiple causes and multiple consequences that are difficult to identify as belonging to the domain of the individual or of society. The forms and contexts of interpenetration of one into the other become, therefore, a theoretical issue to be investigated and debated from different ethnographical perspectives. [3]

Between illness and suffering: a history of the concepts under debate

It can be argued that the debate regarding illness and suffering in the field of anthropology is as old as the discipline itself (GOOD et al., 2010). Suffering is a constituent part of the social world, and therefore the anthropological study of other societies and cultures is always confronted with the issue of illness, which is understood in its relationship to specific social norms, moralities or cultural disputes. Whether it is called *misfortune* (RIVERS, 1926; EVANS-PRITCHARD, 1937), *illness* (FOSTER and ANDERSON, 1978), *disorder* and (or) *affliction* (TURNER, 1970), what is in focus are the "disturbances" that have certain inevitability in the dynamics of life.

Authors including KLEINMAN et al. (1978), KLEINMAN (1980), SCHEPER-HUGES and LOCK (1987), MARTIN (1987), FARMER (1997), HELMAN (1990) and GOOD (1994), among others, represent a traditional Anglo-Saxon line of thought, which became known as medical anthropology. Within this field, using studies with *explanatory models* of illness, the concept of *illness* began to be questioned explicitly, suggesting that the phenomenon commonly referred to as illness in the field of biomedicine could usually be identified as suffering, a "*disease,*" that is, a rupture in the state of well being. In a historical context, the hyphenation of the word "*disease*" (*illness*) represented a demand for the extension of its significance, proffering it beyond a unilateral association with the biomedical field. This highlights anthropology's disposition toward the social, cultural and political nature of illness, based on the understanding derived from innumerable ethnographical studies developed at different times and places, that illnesses are not universal entities; that illness manifests itself differently in different societies, cultures and times; and that there are culturally specific illnesses/sufferings.

These questions became an important focus in the field of medical anthropology (JOHNSON and SARGENT, 1990) and in the field of critical medical anthropology (BAER et al., 1997). This perspective is also known as the anthropology of medicine (PHLEIDERER and BIBEAU, 1991; LOCK and NGUYEN, 2010), in which, since the end of the 1970s, an intense search for new concepts to explain the various forms of illness could be observed. A decisive point of this debate was the distinction between the concepts of "*illness*" and "*disease*" (EISENBERG, 1977; KLEINMAN et al., 1978; KLEINMAN, 1978; KLEINMAN, 1980; YOUNG, 1981; HELMAN, 1990), showing that patients and professionals in the area of biomedicine do not necessarily share the same ideas regarding illness and that this agreement occurs only in distant socio-cultural contexts, in so-called *other cultures*. Even in Western society, it has been possible to differentiate, on the one hand, the experience of the patient —an "*illness*"—and, on the other hand, the view of the doctor—a "*disease*"—that is, a pathology.

Other anthropologists have proposed alternatives to understanding these differences based on a critical recrudescence of dualisms associated with Western Cartesian thought. Frankenberg (1986), for example, re-examines the idea of "*illth*" proposed by John Ruskin, which is constructed in opposition to the idea of "*wealth.*" Ruskin states that just as abundance and wealth carry with them a sense of well being, so the concept of "*sickness,*" when used to refer to discomfort—"*illth*"—is played out socially and culturally. The concept of "*suffering*" goes to the heart of this debate, appearing in the most critical evaluations of the limitations of these conceptualizations and becoming more widely used since the debates on Cartesian dualism gained prominence in the medical-anthropological literature (HAHN, 1984). Subsequently, the idea of "*embodiment*" (corporification, corporeity, inculcation or incarnation, in the various translations of the term into Portuguese) becomes central to the construction of a concept of suffering that is not only expressed in the body but is also fundamentally experienced there (CSORDAS, 1994). The basic point of this debate is that illness is not necessarily related to universal generic pathologies that afflict individuals, which can be experienced differently at different times and in different societies. Rather, it is a matter of showing that different times and societies produce certain types of suffering that are experienced in the body, that is, that are embodied, to the extent that the body is the *locus* of production and constantly

updates the senses (MERLEAU-PONTY, 1962; JENKINS, 1992; BOURDIEU, 1995, 1999 and 2004). The idea of embodiment of the world, as reflected in the title of this paper, is related to this theoretical perspective (CSORDAS, 1990).

It should not be inferred from this historical briefing that medical anthropology has been marked by developmental stages or that the conception of *illness* has been reconceived as *suffering*/*social suffering* in an evolutionary process. This is not the case. I am simply pointing to the fact that there was a significant increase in the 1980s in the size and diversity of the field of anthropology that is concerned with health and illness, which led to an increase in dialogue drawing on different critical theories. For example, post-structuralism and studies of genre increased their competitiveness and in some ways their competence and theoretical-conceptual engagement in the wider field of anthropology (GOOD et al., 2010).

In Brazil, the field of anthropology has followed the disciplinary movement and conceptual expansion of the subject of suffering in its broadest sense. However, the debate has been expressed in concerns over the dichotomies between body-soul, body-mind, thought-action, representation-experience and psyche-soma, among others, and the concepts of *illness*, *suffering* and *disturbance* were projected into the realm of the anthropology of body and health (as this area has been defined in Brazil since the 1990s). It is in this sub-area of anthropological knowledge, despite the divergences in Brazil between more phenomenological and more structural perspectives, that the question of suffering as a non-dualistic experience has been represented in the majority of studies. On the one hand, some scholars have called for a re-reading of the philosophies of Heidegger and Merleau-Ponty, as reviewed by Csordas in the article "Embodiment as a New Paradigm for Anthropology" (CSORDAS, 1990), based on the reinforcement of the collapse of these dichotomies. On the other hand, others appealed to Duarte's reference to recovery of the "physical-moral locution" to express the mediation between corporal and moral dimensions of disturbances (DUARTE, 1994 and 1998). In both cases, Brazilian anthropology can be seen as exhibiting great interest in the issue of suffering, as represented in several Brazilian anthologies, including ALVES and MINAYO, 1994; ALVES and RABELO, 1998; DUARTE and LEAL, 2001; LEIBING, 2004; and CAROSO, 2008.[4]

While taking account of the history of the concept of *suffering* in anthropology, the important issue is to show that studies on suffering possess a long history in the discipline. These studies involve an interesting dialogue with other approaches, drawing attention not only to the diversity of human problems but also to their meanings and their relationship with the political and economic nature of social life. It has been through this process that anthropology has accommodated a consideration of the problem of *social suffering*. Under discussion here is the clarification of the meaning of *social*, the sociological dimension of affliction that can be clearly evidenced in relationships formed in situations of conflict and politically explicit violence or in more concealed and daily forms of violence [5]

Why is suffering social?

According to Kleinman et al., "Social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems" (KLEINMAN et al. 1997 :ix)[6]. In other words, suffering is intrinsically tied to what I call simply *the politics and economies of life*, verified through specific historical and social conditions and configurations. In this sense, it is fundamental to observe how political, economic and institutional powers interlace in personal and daily experience and how people react to events in their daily lives. Social suffering is not about individual suffering, although most of the time it makes this visible, nor is it about corporal suffering, although it manifests itself, as argued throughout this article, in an embodied form. As a socio-cultural experience, suffering exists as an embodied condensation of historical time. In other words, social suffering is *social* not only because it is generated by social conditions, but also because it is, as a whole, an *embodied social process* in historical subjects. Therefore, anthropology, through the recognition of its specificity, can contribute to its significance.

I understand, like the authors mentioned above, that the category of social suffering also has the capacity to unite conditions that are usually extended over different fields such as "health, welfare, legal, moral and religious" issues. The broadness of the category makes it necessary to collapse dichotomies such as those that separate (a) the "individual from the social level of analysis," (b) "health from social problems," (c) "representation from experience" and (d) "suffering from intervention" (KLEINMAN et al., 1997: ix; this author's adaptation) .[7]

To illustrate, I cite two classic examples of the international medical-anthropological literature of Brazil in the area of social suffering. The first example is Nancy Sheper-Hughes's book *Death without*

weeping: the violence of everyday life in Brazil, an ethnography of the 1980s developed in the forest area (Zona da Mata) of Pernambuco state (northeastern Brazil), the area in which are found the highest concentrations of fecundity and mortality in the country and the world. In those circumstances of deep economic crisis, the anthropologist describes and argues what she perceives to be a brutal picture of acceptance and trivialization of the deaths of babies and the meaning of feelings such as maternal love, care, mourning, illness and death in a situation of extreme poverty. This book is considered to be a study on social suffering insofar as it refers to the interrelation between social, political and cultural issues of high infant mortality with the politics and economies of daily life, the embodiment of feelings and the medicalization of life (SCHEPER-HUGHES, 1987).

The second example is Bihel's 2006 book, *Vita: a life in a zone of social abandonment*. This is an ethnography based on a public institution for people in situations of psychic suffering. Although the author uses as a reference the case of a specific individual, following his progress through many years and following his experiences and personal misfortunes, the roles of the public healthcare system and the policies of mental health are apparent throughout the study. In this context, the book is considered to be a study of social suffering because it characterizes the process that is involved from the level of the low-income family across the entire healthcare system, showing the interconnection of historical, social, political, economic and personal levels in the (mistaken) construction of a diagnosis of mental illness and its implications for a person's life (BIHEL, 2006).

As observed, one way to approach social suffering from an anthropological point of view is to contemplate the issue of personal or group affliction in relation to processes that are beyond individual control but that have a direct impact on people's daily lives[8]. It is worth noting that many studies focus on the resistance of groups or individuals in these processes. A reference study in this area is Das et al.'s anthology, *Remaking the World: violence, social suffering and recovery*, which focuses on "how communities which have been marginalized through the structure violence of historical processes or which have faced the trauma of political violence, rebuild their lives" (DAS et al., 2001: vii). [9]

Finally, it must also be noted that social suffering is not exclusively a subject of anthropology. It essentially deals with a theoretical and methodological perspective that has the ethnography of experience as its foundation . [10]

Health problems or social suffering? The case of indigenous people in the south of Brazil

According to Kleinman et al., an important dimension of social suffering is related to political and professional processes, which can involve (1) authorized or contested appropriations of collective suffering, (2) the medicalization of life and (3) suffering relative to public policies (KLEINMAN et al., 1997). These three facets of political/professional processes will serve as a basis for analyzing a situation of social suffering that was evidenced in an ethnography performed with indigenous groups in Rio Grande do Sul.

The first process, appropriations of collective suffering, refers to ways in which different professionals transcribe and/or interpret the suffering of people or communities. Professional appropriations, both authorized and contested, are not rare and can increase the suffering of populations that are already at a disadvantage. The meaning of "suffering" is lost in its deepest sense through various types of appropriation: sensationalism and the exploitation of human suffering to sell newspapers and media news; socio-cultural aspects of groups being made exotic (and thus commercialized) by sociologists, anthropologists, and other scientists; and the transformation of social suffering into diagnostic categories ("*diseases"*) on the part of health professionals.

The second process is the medicalization of life or the regulation of bodies and people. To the extent to which the problems of life ("*dis-ease"*) become understood and represented as illness ("*disease*"), they supposedly become treatable through the use of medicines or medical procedures with implications for morality and subjectivity (WEITZ, 2003).

The third process relates to public policies, which even when intending to reduce the suffering of both people and historically disfavored groups can intensify it, either intentionally or unintentionally. An example is the bureaucratic characteristics of public agencies, which create intricate bidding processes that delay the release of resources required to solve the immediate problems of populations that are either disfavored or in crisis.

These three processes have been evident throughout the development of the project, *Indians in the Urbanity: the politics and economies of suffering*, an ethnographic research project in which I have

followed the relationships of indigenous people who live in Porto Alegre (the capital of Rio Grande do Sul) and its outskirts with life in the city, that is, with institutions and people with whom they are related. Because I am not an indigenous anthropologist but a medical anthropologist in training, my focus has been on indigenous health issues.

In this ethnographical context, in the second semester of 2009, I participated as researcher and supporter of the cause of indigenous people at the headquarters of the National Foundation of Health (Fundação Nacional de Saúde – FUNASA) in Porto Alegre. During that period, I began to understand more clearly what *social suffering* means for anthropology, primarily in the guise of suffering that seems to intensify the very institutions that have the ability to alleviate the suffering of indigenous people[11]. With the authorization of those present, I made a voice recording of the declarations, which were characterized by great solidarity among the different indigenous groups and by the defensive position of the few employees of FUNASA who were present, who made great efforts to placate the group of activists. Chieftains of the Kaingang, Guarani and Charrua communities appeared, protesting what they identified as *the problem of indigenous health*. Maria, the leader of Kaingang of Rio Grande do Sul, one of the indigenous communities attending the meeting, made a declaration about the difficulties experienced in her community. It was significant that her speech was uninterrupted, which must be relevant to the interconnection of related events and therefore to the dramatic interrelationship of the social, economic and political spheres. I present her speech below, in segments, so that it is possible to discuss it alongside the issue of social suffering, which is the main focus of this article.

I must stress that Maria's speech has a strong accent that is characteristic of southern Brazil, in which the plurals lack the letter "s" at the end and verb conjugations do not always follow grammatical precision. I transcribed her speech below, with some adaptations for written grammatical language. I tried to increase the fluidity of the text without affecting the order or the original sense of her speech.

It is worth noting that, for ethical reasons, several qualitative studies avoid disclosing the true name or characteristics of their informers, which is fully justified. However, in the present case, this was not considered appropriate because of the public leadership position of Maria, who was making a speech in a public meeting in which her Kaingang identity was essential. By contrast, in this situation, I considered that it would be ethically improper to omit her name or to use a pseudonym or fail to mention her ethnic origin to avoid identifying her. I transcribe Maria's story below (in italics), interspersing my commentaries and taking the responsibility of contextualizing her argument and focusing on the main object of this article, which is *social suffering* from the perspective of anthropology.

It is worth noting that since 2010, the politics of indigenous health have been subject to important reformulations, leaving the sphere of the National Foundation of Health (Fundação Nacional de Saúde) – FUNASA for that of the National Indian Foundation (Fundação Nacional do Índio) – FUNAI. However, this does not have implications for the content no the analysis of the ethnographic case presented in this article.

The protest began with the participants introducing themselves, followed by the emotional depositions of the various leaders present. I selected Maria's speech because it condensed several issues presented by other leaders, starting with what she understands to be prejudice and the exclusion of indigenous people on the part of the institutions that are supposed to support them in healthcare issues, followed by the problems of negligence and indifference. In her words:

> *I find that, as a person speaking, the mayor doesn't want to see the face of Native Indians there. From City Hall they sent us to FUNASA; there in FUNASA, they sent us to City Hall and [from there] to the pharmacy. Everything was locked. [There were no (bus) tickets] ... It has been three months that it does not go there. It has been three months that I come for tickets here, but there is never a ticket. From there I ask for tickets. So they send forty. It takes more than three months, four months, five months?*

In this first segment, Maria specifically mentions the actions of *City Hall* and *FUNASA*, institutions that have the responsibility for indigenous healthcare. She mentions the buck-passing game between the institutions: *City Hall* to *FUNASA* and vice versa, from there to *the pharmacy,* all of the doors of which were *locked*, which I believe to have a literal meaning as well as a figurative one. This door-to-door movement, according to Maria, requires transportation, which she explains in terms of *tickets* to ride the bus. As the leader of her community, she has the right to receive free bus tickets from *FUNASA* to take care of the health issues of her community. It has been *three months*, according to Maria, since there has been medical attention in the village, and even when she went to obtain *tickets* so that the sick people could attend a public healthcare service, according to her, *there is*

never a ticket. When she finally obtains *forty tickets*, it is an exact number that must last an inexact number of months: *three*, *four* or *five* perhaps. It can be noted in the first segment of her declaration how the condition of indigenous villagers is a historically and economically specific social condition, which is immersed in the confusion of public policies regarding the people, with great implications for the social suffering of the group.

In the same speech, Maria mentions the problem of dental attention for members of her community:

> *They send the molds all with mistakes, everything changed… so all the elderly are there, trying to chew as best they can. People even look in pity at the poor wretches there, the other old people that are there.*

In this passage, she mentions a fact that she explained to me later in more detail: that when dentists went to the village to provide dental treatment, in some cases they opted for extraction and prostheses. However, in her understanding, the problem was not resolved because the teeth *molds* were *mixed up* and the prostheses did fit adequately, causing greater pain and discomfort to *the elderly*, who, now, are trying to *chew as best they can*.

It is not appropriate here to speculate on the conditions of this dental care because there are insufficient ethnographical data available to go into further detail on the procedure. Her story is sufficient to call attention to the aspect of the contact with institutions in which the professional approach directly leads to the increase of a specific health problem, within the bigger picture of social suffering. This is because, in addition to being a problem of an already vulnerable group, *the elderly*, the problem is related to the historical phenomenon of tooth deterioration of indigenous people and to the neglect of indigenous healthcare in Brazil . Several scientific studies (ARANTES et al., 2001; MOURA et al., 2010) have described the negative impact on the oral health of indigenous populations caused by the westernization of alimentary habits with the introduction of white flours and sugars.

Knowing that chewing is a fundamental part of nutrition, Maria was also asked how *the elderly* are supposed to feed themselves if they did not have teeth and were unable to use the prostheses supplied. She replied by saying that these people were quite weak in terms of weight and health because they were unable to chew. Clearly, *the elderly* are not in a state of weakened health just because they are unable to chew properly, but the fact that they are having all of their teeth extracted and not being given adequate replacements reflects quite a surreal picture of the process of social suffering.[12]

As her speech continues, Maria returns to talking about exclusion and connects it with the issue of children and the incoherence that she observes in relation to indigenous healthcare typified in the simultaneous scarcity and excess of resources:

> *They do not want to see the face of the Indians. Certainly, FUNASA does not want to see the face of the Indians there. Hitchhiking to take small children to healthcare centers [to have] a vaccine. After they arrive there, the Indians are used as guinea pigs, making a lot of injections: six vaccines! Then there is no ticket, there is nothing for Indians who are going there. Eliane went there, but they did not want to make the vaccine. [We] are going as we are able, to make the vaccine. However, they always make inside there [the village] ... 'However, you have to understand Maria …' [It seems] quite easy for you to arrive here! Those who are there [in the village], malnourished, like the three or four children, so malnourished there. They come here to FUNASA, there is a lot of milk, but they do not give … They were there to perhaps do the worm things during two or three years. Meanwhile, the children fall ill again; one of them with six, seven vaccines. However, it is not the fault of the Indians. So many children late [for vaccines]. However, they had always come here to do, why is it only now?*

Reiterating her feeling that the Indians are not welcome at FUNASA, Maria explores the contradiction that she perceives in that her people have *to hitchhike*—that is, to make a concerted effort to transport themselves to the healthcare service—so that the children can receive a vaccine, and yet when they arrive they are submitted to a great number of injections. This scenario defies logic because if it was really necessary to administer as many as *six, seven* vaccines, why did FUNASA not go to the village to administer them? This leads Maria to suspect that perhaps the vaccinations are not as necessary as they seem and/or that the children are being used as *guinea pigs*.

Perhaps the person whom she calls *Eliane* could, on that occasion, have been the healthcare agent, as she gives the impression of a person who at times is at the healthcare center and at other times goes to the village. Maria states that she is unable to mediate and therefore asks Maria *to*

understand what is, for her, incomprehensible. How can she understand that she has *three or four malnourished children* in the village while the headquarters of FUNASA *has a lot of milk* that *they will not give out*? Moreover, how can she understand that *they* made worm treatment for three consecutive years (or were they made three years ago?) and never came back? Because of this situation, Maria believes that the problem of *worms* returned, and the children in her village are *falling ill*. This also may explain why they needed *six, seven vaccines* because she believes it could also be an indication that the children are potentially ill. Finally, she comes to what seems to be the underlying issue: if the Indians have some value, why did *they* stop going to the village?

Returning to her initial point that *they do not want to see the face of the Indians*, I asked Maria what she meant when she said, "*However, is not the fault of the Indians."* I understand that she wants to stress that they have been proactive with regard to health, that is, that they search for resources but encounter many difficulties, and thus the delay in vaccines cannot be attributed to them. At the same time, it occurs to me that she can be referring to a more complex process of change in historical and social conditions, in which the villagers are involved without even having been asked to participate. Consequently, they seem to suffer from the common syndrome of immigrants in a foreign country: in addition to not mastering the local language, they do not know the rules of participation in society, the great irony in this case being that they are in fact the true natives of the country.

In the following segment, at the end of her speech, Maria puts more pressure on the relationship with the assistance institutions. Still without being interrupted, she brings up an unexpected subject, which seems not to be related to the healthcare service or to teeth, or to vaccines, or to the lack of transportation mentioned previously. She now wishes to focus on the sanitary conditions that she also regards as the responsibility of FUNASA:

> *"… the hoses are all broken down there. There the Indians went to make [fix it]… the tank fell, broke. 'Ah, it isn't possible to bring another tank'. We do the needs in the open air, there in the wood. They did not set one toilet . Also another thing. We are there. We are already used to this … However, at least they could have made a small private place for us … I have pity for the children of the community that are so suffering there … guinea pigs. So, that's it, what my friends said: people just have to get on with it."*

In this last segment, Maria refers mainly to the problem of the water supply in the village. First, the *hoses* that brought water from a well, evidently an improvised form of water supply for the community, had been damaged. It can be noted from her story that there was an attempt to improve water distribution by placing a water tank in the village, but from what can be inferred, the effort of the members of the community to install it was unfruitful because the tank *fell* and *broke*. The third step, that is, obtaining a new water tank, was thwarted, as Maria tells it by repeating the FUNASA words: "*Ah, it isn't possible to bring another tank."* The presence of a water reservoir is crucial to guarantee the most basic forms of irrigation and hydration of a village as well as in confronting the problem of the lack of sanitary installations. They *do their needs* in the *woods*, and what I understand from her speech is that *they are used to do it*. If this were true, she probably would not highlight the importance of some form of privacy to *do their needs*, in her words, in *a small private place*.

Finally, Maria again refers to the children who, according to her, *are suffering there*, implying that ultimately it is about the continuity of her people and, in this sense, not about the suffering of isolated individuals afflicted by illness but more about a community that, historically, consistently experiences social suffering. Her final point about *having to get on with it*, however, was demobilized, as I will explain below with my final considerations

Final Considerations

From the transcription and the commentaries on this ethnographic case, I attempted to demonstrate how, from an anthropological perspective, it is possible to recognize a process of social suffering. As stated previously, to do this, it is necessary to face the challenge that the inseparability of physical, psychological, moral and social dimensions of suffering places on our usual ways of dealing with and understanding human phenomena.

Many might dismiss the story of Maria as confused because she presents problems of various types and origins and connects them in an apparently disordered sequence. However, from the point of view of social suffering, it makes sense to think that an inseparability of social and individual levels exists -- "health from social problems, representation from experience, suffering from intervention" (KLEINMAN et al., 2007) -- and this is simply reflected in her declaration.

In this context, it is worth mentioning that several declarations of other indigenous people on the same day also spoke to this type of interconnection of spheres of life. Ethnographically, I noted that

the declarations of the indigenous people were usually long, very emotional, partly in Portuguese and partly in their native languages, calling for more effective action from FUNASA and concluding with the threat to remain in the building and keep all of the non-indigenous people present locked as hostages[13]. Evidently, this active form of confrontation provoked much discomfort in the institution technicians, who decided to make a list with the requests of each community present. In the words of one of the technicians:

> *"What I would like to say to you is that: what is the request of each community? … I still have not managed to see clearly: whether it is the medicine, whether it is the car, item by item ...."*

What the technician perhaps did not manage *to see* was precisely the fact that the speeches of the indigenous people revealed another phenomenon, which can only be understood as a set of inseparable parts. In this context, it is not the lack of *a medicine* or the lack of *a car*; nor is it a separate item or a list of them that can explain the *health problem* of the indigenous people. The situation is simply an illness bound to social, economic and political exclusion that is associated with an entire era. I should say that the indigenous people, when hoping for FUNASA to take some action, demanded dignified *healthcare* treatment. That is, their interpretation is grounded, in a certain sense, in the paradigm of health and illness. However, it can be noted in their testimonies that *health problem* has an expanded meaning, including, for example, prejudice (*no one wants to see the face of an Indian*, according to Maria), which is not a disease but nonetheless contributes enormously to social suffering.

At the end of the meeting when at the request of the FUNASA technician a list was drawn up with the demands of each community, I was left contemplating the power of demobilization and the emptiness of meanings brought by the itemization of the communities' requests imposed on the political process that unfolded in the meeting. Social suffering of indigenous peoples has frequently been reduced to a list of needs that are transformed into simple requests. Thus, community "A" supposedly lacks a healthcare center in the area, an indigenous healthcare agent, a car for the transportation of sick people and a water tank; community "B" lacks an indigenous healthcare agent and a sanitation agent, medicines and a taxi for the transportation of sick people. Thus, the interconnected elements were lost that contributed to social suffering and that made sense of the indigenous people's true political demands for a more dignified life for themselves and their descendants.

The role of anthropology in approaching issues related to healthcare has been vast and diversified, from practical exercises used by the profession within healthcare services and governmental and non-governmental organizations to perspectives leaning more toward academic reflections on the phenomenon of illness. In all situations, I am suggesting that the contribution of anthropology to the debate on social suffering is made through a combination of theoretical and methodological tools that allow us to ask, by engaging with subjects and considering their history and social situations, how suffering manifests and is recognized and what the political and ethical implications are of the different types of recognition.

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Notes

1 This article was written under the auspices of the post-doctorate scholarship of Capes, Process 5043/09-3.

2 In the original: "the devastating injuries that social force can inflict on human experience."(Kleinman et al., 1977: ix).

3 Das refers to her preoccupation with the slippery relationship between the collective and the individual, between a genre or literary style as a whole and the individual telling of stories. Here, she introduces the issues that arise from this assumption. In the original: ".. my concern is with the slippery relation between the collective and the individual, between genre and individual emplotment of stories" (Das, 2007:2).

4 I should also stress here the intense representation of the problem in the congresses of ABA, ANPOCS, RAM, and ABANNE, even before the constitution of the specific area in Brazil but notably increasing since the beginning of the 1990s.

5 See, for example, Langer (1997), on questions related to the atrocities of the Holocaust; Woodward (2000) on the peculiarities of violence in the Balkan Peninsula; and Das (2007) on the collective violence and the politics that accompanied the process of independence in India.

6 In the original: "Social suffering results from what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems" (Kleinman et al., 1997: ix).

7 In the original: "*They collapse old dichotomies—the example will be those that separate individual from social levels of analysis, health from social problems, representation form experience, suffering from intervention* " (Kleinman et al., 1997: ix)

8 Two interesting cases on a specific illness, HIV/AIDS, seen from the point of view of social suffering can be found in

the studies of Farmer in Haiti (Farmer, 1996) and Fassin in South Africa (2007).

9 In the original: "(…)how communities which have been marginalized through the structure violence of historical processes or which have faced the trauma of political violence, rebuild their lives."

10 On the ethnography of experience, see Bruner (1986) and Kleinman (1991).

11 It is worth noting that since 2010, the politics of indigenous health have been subject to important reformulations, leaving the sphere of the National Foundation of Health (Fundação Nacional de Saúde) – FUNASA for that of the National Indian Foundation (Fundação Nacional do Índio) – FUNAI. However, this does not have implications for the content no the analysis of the ethnographic case presented in this article.

12 It is important to clarify that I am not suggesting that this problem is exclusive to indigenous populations, as it is known that almost all socially and economically disfavored social groups in several Brazilian situations suffer from a variety of oral health problems.

13 It is possible to argue that it is about a style of discourse, but given the constraints of time and space, this subject will be addressed in another article.