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The discovery of qualitative approaches in health research

A challenge for medical anthropologists

Brigit Obrist van Eeuwijk

Since the 1980s there has been a steady growth in demand for medical anthropologists in national and international health research. At home and abroad I now often hear health researchers and practicioners say «We need an anthropologist». Such statements were very rare some fifteen or twenty years ago. The increased recognition of medical anthropology can be partly attributed to a general trend, namely the discovery of qualitative research by representatives of the «hard sciences», partly due to innovative efforts of medical anthropologists working in the applied field. The aim of this paper is to reflect on these developments based on my personal experiences.

What is qualitative research?

Qualitative research is currently *en vogue*, as the growing body of literature on this topic illustrates. Despite, or maybe just because of this development, researchers cannot decide on a precise definition. Norman Denzin and Yvonna Lincoln, the editors of a recently published *Handbook of qualitative research*, make the laconic statement: «Qualitative research means many things to many people» (Denzin and Lincoln 1994a: 4). In fact, qualitative research does not belong to a single discipline, it is used in anthropology, sociology, education, psychology, history and literature. As anthropologists we find ourselves in the paradoxical situation that health researchers show a keen interest in our discipline at a time when it is «perhaps the most hotly contested site in qualitative research» (Denzin and Lincoln 1994b: 203). The 1980s were «a time of ferment» (Nichter 1991: 2) in academic anthropology characterized by debates between «conventional» anthropologists and advocates of critical theory, feminism and postmodernism. Several paradigms are currently competing, or have until recently competed, for acknowledgment as *the* paradigm of choice in guiding qualitative inquiry (Guba and

Lincoln 1994: 105), and this is reflected in current debates within applied medical anthropology. Kleinman, for instance, critized conventional medical anthropologists for exploring symbolic and religious links rather than focusing on issues of medical interest and based his approach on the constructivist paradigm to study the «cultural construction of illness as a psychosocial experience» (Kleinman 1980: 71). His approach stimulated considerable research in psychiatry, medicine and medical anthropology and became known as «clinically applied anthropology» (Chrisman and Maretzki 1982). This approach was contested by proponents of critical theory such as Scheper-Hughes (1990) and Singer (1990) for «medicalizing» medical anthropology and for disregarding the impact of social and political relations. Their theoretical stance has become known as «critically applied medical anthropology». We thus see that qualitative research in «the field» of medical anthropology is far from a unified set of principles. On the contrary, it is fraught with tensions and contradictions.

A plea for a multipositioned stance

Not all medical anthropologists pursuing applied work have been or are actively engaged in «theory posturing» (Nichter 1991: 2). Many, in fact, advocate a multipositioned stance: they acknowledge that each approach focuses our minds on a particular perspective; the selection of one or the other approach thus depends on the questions we want to investigate.

In 1992 we were commissioned to explore the role of «culture» in the health problems faced by Turkish and Kurdish people in Switzerland (Obrist van Eeuwijk 1992). We selected Kleinman's approach to guide our study because we wanted to analyze how these people cope with illness in concrete, day-to-day settings. Kleinman (1980) initially developed his approach in clinical settings. His intention was to cultivate a sensitivity to culture among practicioners by analyzing the complex interactions between patients, their families and friends, and health practicioners in coping with a specific health problem. Had we had a different goal in mind, we could have sharpened our minds on «critical theory» to investigate how social, political, cultural, economic, ethnic and gender aspects shaped the illness experience of these Turkish and Kurdish immigrants. In fact, we did include these aspects in our analysis, but not as the main focus and not in the form of a critique of ideology and power which is «at the heart of all critical theories and methods» (Scheper-Hughes 1992: 171). Had our qualitative inquiry been guided by this theoretical orientation we would have conducted a reflective examination of the multi-layered relationships of power and ideology which ultimately cause the suffering of these immigrants and refugees.

Perspective or focus

The preceding discussion has shown that qualitative inquiry, like all research, is very much guided by the definition of the research perspective. Scheper-Hughes and her colleagues use a wide-angle lens to study health and illness in a large political and economic context. Conventional anthropological studies tend to use the «normal» lens and portray people's illness experiences in the everyday world of their particular community. My study of malnutrition among the Kwanga (Obrist van Eeuwijk 1992) falls into this category because it describes different spheres of Kwanga life and explores the conceptual links between these spheres which shape local perceptions of what is healthy and unhealthy growth in children. Kleinman (1980: 29) postulates to narrow the focus of «basic issues of medical and psychiatric practice (indigenous or Western): the experience of illness on personal and so-

cial levels, health seeking behavior, patient-practitioner relationships, and the healing process». Still another group of medical anthropologist narrow the focus down on a specific disease, for instance diarrhea or acute respiratory infections. Nichter (1993) reviews much of the anthropological literature on diarrhea research.

Until recently, biomedical concerns have dominated the definition of perspectives in applied health research. This has begun to change in the past decade as social scientists, including medical anthropologists, have become consultants or even staff members of research committees, for instance in the Social and economic research steering committee of the Tropical and disease research programme of the UNDP/World Bank/WHO (WHO 1995), the Control of diarrheal diseases programme of WHO (Pelto and Pelto 1992) or the Applied diarrheal research project at the Harvard Institute for international development (Del Vecchio Good 1992). These pioneers often achieved that researchers sponsored by their agency were allowed to expand their field of inquiry and use a broader research perspective.

Transdisciplinary research

The trend in the field of applied health is towards «transdisciplinary research» (Nichter 1993, Bennet 1995, Tanner and Harpham 1995, WHO 1995). This is a new challenge for most medical anthropologists, and in fact any academic who works in a heterogeneous group. «... [S]ocial scientists are keen to defend the singularities and methodologies of their several separate disciplines, and indeed have seen this methodological pride as a defence against attack from the "hard" sciences. But field problems are not so easily divided: they respect no discipline, not even those of the "hard" sciences.» (WHO 1995: 155) Anthropologists who want to participate in the process of solving health-related problems will face a difficult task, especially if they try to combine academic and applied medical anthropology. Their path will be riddled with dilemmas, and one of them is what Kleinman calls the «dilemma of divided loyalties». Kleinman (1982: 12) reflects on his role in a clinical setting: «A large part of the anthropologist's dilemma in the clinical context is to take up a stance that is intrinsically divided, collegial, concerned with the practical resolution of clinical problems and yet at the same time, autonomous, concerned with clarifying an independent anthropological theory of illness and healing that stands on its own.» There is no easy solution to this dilemma. In fact, it is inherent to all transdisciplinary endeavors, be it in applied clinical work, in disease focused research, in urban health research, or in other applied fields.

On the other hand, it can also be motivating and thought-provoking to work in a transdisciplinary team. Twice I had the opportunity to participate in workshops that were organized in Tanzania by the Tropical disease research programme of the UNDP/World Bank/WHO and the Swiss tropical Institute. In both workshops the aim was to build capacity in qualitative research among African health researchers. One of the lessons I learnt was that «methodological sophistication» (Pelto, Bentley, Pelto 1990: 274) is essential, if anthropologists are to realize their potential for contributing to the solution of health-related problems. In other words, approaches and methods have to be made explicit and techniques should be expanded and extended beyond the usual combinations. Many of these improvements are a result of the development of Rapid assessment procedures (see Manderson, Aaby 1992), but they can also be put to good use in long-term field research. Another lesson was that collaborative research in muli-national teams can be an enriching experience. The exposure to differing perspectives sharpens our minds and forces us to critically reflect on what has become «conventional» in our own research community.

Conclusions

The discovery of qualitative approaches in health research is, indeed, a challenge for medical anthropologists pursuing work in the applied field. Some of us may take a highly critical stance and call the «inevitability (...) of the whole biomedical health enterprise» into question (Scheper-Hughes 1990: 191). They may decide to «dis-identify with the interests of conventional biomedicine» (ibid., p. 192). Others will opt for a multipositioned critical stance as a basis for collaboration with health researchers who feel «they need an anthropologist». This stance opens our eyes and minds to the multidimensional perspective in our own discipline and, at the same time, prepares us for collaboration with representatives of other disciplines. This collaboration may again take different forms, from long-term field research to collect background information against which future health interventions can be planned, over short-term assessments and evaluations, to collaborative, transdisciplinary development of research programmes. Medical anthropology certainly offers many opportunities for researchers who wish to work in the applied field.

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Abstract

This paper reflects on the challenges posed to anthropologists by the recent discovery of qualitative research by our colleagues in the medical field. For us anthropologists «qualitative research» is not a unified set of principles, not even within the sub-discipline of medical anthropology. Instead of fighting amongst ourselves as to which is the best theoretical perspective and whether «contextual» or «focused» research is more relevant, we should advocate a multipositioned stance. This means weighing the strengths and weaknesses of each theoretical perspective in view of the particular question(s) we want to investigate. A prerequisite for this stance is a firm footing in our mother discipline, anthropology; this becomes even more important if we endeavour transdisciplinary research.

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