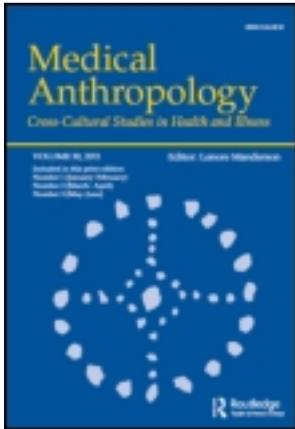


This article was downloaded by: [87.24.33.129]

On: 25 February 2013, At: 01:36

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Medical Anthropology: Cross-Cultural Studies in Health and Illness

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/gmea20>

Allergy Narratives in Italy: 'Naturalness' in the Social Construction of Medical Pluralism

Roberta Raffaetà^a

^a Department of Sociology and Social Research, Trento University, Trento, Italy

Accepted author version posted online: 02 Oct 2012. Version of record first published: 13 Feb 2013.

To cite this article: Roberta Raffaetà (2013): Allergy Narratives in Italy: 'Naturalness' in the Social Construction of Medical Pluralism, *Medical Anthropology: Cross-Cultural Studies in Health and Illness*, 32:2, 126-144

To link to this article: <http://dx.doi.org/10.1080/01459740.2012.732632>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.tandfonline.com/page/terms-and-conditions>

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Allergy Narratives in Italy: ‘Naturalness’ in the Social Construction of Medical Pluralism

Roberta Raffaetà

Department of Sociology and Social Research, Trento University, Trento, Italy

Based on an ethnographic study conducted in both biomedical and complementary and alternative medicine settings in north Italy, I explore how people and practitioners make sense of allergy and how patients utilize plural healing options. Despite a wide range of medical modalities, people categorize and use medicine according to whether they are ‘natural’ or ‘not-natural,’ thus dissolving any potential confusion between diverse therapies. I analyze how the concept of naturalness relates to allergy and medical pluralism. Nature is perceived as opposed to pollution, the first associated with a reassuring and idealized past and the latter to a modernity riddled with uncertainties. Participants associated a diverse set of meanings with nature, permitting them the syncretism of different medical modalities. Medical pluralism in the study area is an uneven platform for discussion and experimentation, the outcome of historical and cultural context and local entanglements of power.

Keywords *allergy, Italy, naturalness, patients’ perceptions, pollution*

Biomedical practitioners in Italy are reluctant to recognize as sick many people who self-diagnose allergy and, as a consequence, many sick people lack a diagnosis (Raffaetà 2011a, 2011b). Allergology is generally narrowed to the treatment and cure of people with symptoms caused by immunoglobulin E (IgE) reactions (called true allergies). Many people suffer from symptoms very similar to true allergies, but because they lack the detectable involvement of immunologic mechanisms, they are regarded as experiencing pseudoallergies. In the study area, a city in northeast Italy, many people rejected as having a true allergy turn to complementary and alternative medicine (CAM) to manage chronic health conditions: according to Senna and colleagues (2005), 66% of patients had consulted a CAM practitioner; a very high percentage when compared to other countries in Europe (Bielory 2002; Schäfer 2004).

In this article, I illustrate the association of CAM and local interpretations of allergy. People associated allergies with the influence of environmental and social factors on health, and considered modern life to be a source of pollution and ill health. CAM therapies are perceived as counterbalancing the negativity of modernity, because they are regarded as ‘natural’ treatments. The concept of ‘nature’ as used by people with allergies brings together different understandings

ROBERTA RAFFAETÀ obtained a PhD at the University of Lausanne in 2008 and is currently Marie Curie COFUND-PAT postdoctoral research fellow at Trento University, Italy. She has conducted research on allergy, vaccinations, and medical pluralism, and is now studying migration, parenting, belonging, and identity politics.

Address correspondence to Roberta Raffaetà, Department of Sociology and Social Research, Trento University, Via Verdi 26, 38122 Trento, Italy. E-mail: roberta.raffaeta@unitn.it

of health and healing practices, providing people with a traditional symbolic resource to address uncertainty. Next, I draw on the literature from medical pluralism and embodiment and the social and cultural construction of 'nature' and 'naturalness' to explain how and why people use different modalities in the context of understandings of risk.

METHODOLOGY

I draw on ethnographic research undertaken between 2004 and 2008 (14 months of field work in total) in a medium-sized city with an ethnically diverse population of 265,000 inhabitants in northeast Italy. The research involved interviews and observations of the treatment of allergy in a specialist unit of a public hospital The Allergy Unit, composed of four specialist allergists and four nurses, was regarded as one of the best in Italy in terms of its active engagement in clinical care and research, with an up-to-date website and its staff providing commentaries in television and radio debates. This is quite exceptional for an Italian public hospital, for while access to health care is inexpensive, hospitals generally lack high-quality infrastructure, services, and resources. The excellence of the Unit reflects on the good will and professionalism of the staff.

I established the biomedical perspective (Raffaetà 2011c) of the Unit through four semistructured interviews, one focus group with four nurses, the collection of informational material produced for patients, and the analysis of the internal guidelines concerning diagnostic techniques and treatment. Daily, for a period of about three months, I observed and recorded doctor-patient interactions, and attended and video-recorded consultations and diagnostic sessions. During this time, I also conducted semistructured interviews with 28 patients, identified to allow variation in age, gender, and ethnicity and in reported symptoms, regardless of their diagnostic outcome. I did not focus on any particular kind of allergy, but rather, on the variations in categorizations and diagnoses among different actors (allergists, patients, CAM practitioners).

Twelve patients had used or were using CAM, and they referred me to 13 CAM practitioners. I was able to contact 12 of these, all of who agreed to an interview. I identified and interviewed three additional CAM practitioners. While I could not spend as much time in their clinics as in the hospital because of their private nature, CAM doctors were interviewed in their clinic, where I could note equipment and overall clinic style. Nine CAM practitioners introduced me to patients suffering from allergic symptoms, and they were also interviewed in their homes or bars. The CAM approaches that research participants used included homeopathy, iridology, pranotherapy, acupuncture, chiropractic, Ayurveda, psychosomatic medicine and, in four cases, mixed approaches. Twelve CAM practitioners of 15 had a formal education in biomedicine, and subsequently had decided to specialize in a CAM approach.

Around 5250 doctors are registered as doctors in the city's study area and its province, and of these, only 16 specialized in allergology, although in 2011 the telephone directory (Yellow Pages) listed 209 doctors who promoted themselves as expert in the treatment of allergy. Most research participants consulted CAM practitioners who had firstly trained in biomedicine, and had then specialized in one or more other modalities. CAM practitioners (primarily practicing acupuncture, homeopathy, and/or mixed approaches incorporating naturopathy) have practiced in the study area since the 1980s, but the numbers are uncertain and the professional register of doctors does not record CAM specializations because these modalities are not fully regulated.

The number of CAM practitioners who do not have a formal education in biomedicine is particularly difficult to identify, because they are not clearly defined and many work in beauty parlors or massage centers, and are known to clients by word of mouth.

Ethics approval was granted by the study hospital. Informed consent was gained for interviews, recordings, and for my observations of consultations. Interviews were transcribed verbatim and field notes were analyzed thematically, with analytic categories emerging to inform the development of further coding. I made all translations from Italian to English. When I quote participants, I use pseudonyms.

Even if a consensus on the opportunity and modality for evaluating the validity of qualitative research is far from achieved (Sparks 2002; Wainwright 1997), it is both ethically and politically necessary to be accountable for certain aspects of one's research: "Rigor is the means by which we show integrity and competence; it is about ethic and politics, regardless of the paradigm" (Tobin and Begley 2004:390). Against "methodolatry" (Janesick 1994), I believe that research validity relies less on techniques and criteria than on attitude and state of mind; still, accountability is important, especially for research that does not consider reality as fixed and unique but as fluid and multiple (see, for example, Mol 1999); validity claims shift from data to the research process and the researcher, who has the ethical duty to make explicit his or her attitudes and provide evidence of her or his trustworthiness (Sandelowski 1993). Following Whittemore, Chase, and Mandle (2001), I employed the criteria of credibility, authenticity, criticality, integrity, and thoroughness to think through my research. *Credibility* refers to the consistency of research participants' views and the researcher's representation of them. The efficient and effective saturation of specific categories, such as that of pollution, lowered the risk of misunderstanding and misrepresentation. I conducted follow-up interviews with 19 patients from the initial sample during which I checked with participants my understanding and discussed my interpretation, not to seek for repeatability but to allow for the co-construction of reality, a form of truth negotiated through dialogue. *Authenticity* refers to the awareness of subtle differences in participants' accounts. This goal was pursued by paying maximum attention to contradictions, as emerged both in individual accounts or in comparisons between them; by choosing a pluralistic sample composed by various cases of allergies, rather than focusing on one type (e.g., food allergies), and reflecting on their possible differences and negative cases; and by conducting research in diverse settings (hospital and private clinics). *Criticality* is the degree of critical appraisal. I was forced to be critical, enhancing my responsiveness (Morse et al. 2002:17) from the time I commenced fieldwork, because the data were very different from my initial hypothesis. During the entire research, I endorsed a "triangulation state of mind" (Miles and Huberman 1984:235), for example, by collecting statistics, analyzing biomedical documents, undertaking a literature review and historical analysis, and checking for contradictions in narratives and between concepts and practices, striving for the final goal of adding "an additional piece to the puzzle" (Knafl and Breitmayer 1991:229). Criticality was also enhanced by my multiple academic membership: my initial immersion in the humanist Italian tradition, complemented by the French and German tradition at the University of Lausanne, Switzerland, and my further work in Australia, where I learned a great deal about research and publishing in the English-speaking (and writing) world. Researchers' mobility is often silenced in method's accounts: it is a resource but also a challenge that requires greater reflection about its effects on research. The *integrity* of the research, the recursive and repetitive checks of validity, were accomplished to reach a comprehensive 'goodness' (Smith 1993) by presenting findings to numerous conferences and interim

workshops, and through the dialogue with this journal's reviewers. Reflecting on reviewers' comments helped me to rethink specific issues, cover gaps, and see undiscovered spaces for analysis. *Thoroughness*, reflecting the completeness of research, was assisted by the use of maps and charts (Clarke 2005), which provided me with a structural overview of my argument and helped me to visualize how it holds together.

THE ALLERGOLOGY VERSION

Explicative Model

Understandings of allergy expressed by doctors working in the public hospital strictly adhered to the most orthodox interpretation of allergy in the scientific community. The Unit is a partner in GA²LEN (<http://www.ga2len.net/fp6.html>), a network of excellence started in 2004, comprising leading European clinical and research facilities in allergology and is associated with the European Academy of Allergy and Clinical Immunology. In orthodox allergology, immune processes play a fundamental role both in defining and in diagnosing allergy. Allergies are defined as reactions "initiated by immunologic mechanisms" (Johansson et al. 2001:817), which can be of four diverse types. The predominant trend is to focus the practice of allergology on the first type of reaction: immediate reactions involving IgE antibodies, also called 'true allergies.' Orthodox allergology excludes environmental pollution (with the sole exception of allergies involving airways, for which smog might worsen symptoms) as a possible cause of allergic diseases (von Mutius et al. 1992; Wardlaw 1995). Dr. Ferrari is particularly adamant:

I might even say that they [*allergies*] are linked to . . . I mean . . . to . . . to the number of existing television channels. It is the same logic, I mean, it is the same kind of observation. Since the relationship between allergy and pollution has never been demonstrated, they are just two things that have simultaneously increased. I might make a similar comparison, as: until 30 years ago there were three television channels, now they are 30 . . . maybe television is the cause of the increase in allergies? . . . or . . . I don't know . . . the fact that we have less children, I mean . . . yes, it could be that, because we have less children . . . or obesity?! Now people are more overweight than before. I am making these kinds of comparisons to show that it is very easy to find connections with . . . with anything.

People, instead, say that allergies are provoked by substances from the natural environment because the environment is polluted by chemicals and is no longer natural. The gap between allergists' and people's understandings of the causes of allergy results in great discomfort to patients, who feel that their ideas and needs are not met.

The most established explicative framework used by allergists is referred to as the "hygiene hypothesis" (Strachan 1989), whereby allergy is regarded as an aberrant immune response derived from the cultural imperative of hygiene, which has resulted in fewer infectious diseases, so forcing the immune system to abnormal inactivity. As a result, the immune system activates randomly against harmless substances such as pollens, bananas, or apples.

Diagnosis and Treatment

The most common tests used to establish allergy are the prick test, the patch test, and the provocation test; all involve immunologic reactions of IgE. The choice of test depends on the allergist

and his or her pursuit of candidate diagnoses. In the prick test, a solution containing the suspected allergens is applied to the skin of the lower arm. The skin is then pricked with a needle so that the allergen gets under the skin. If the patient has an IgE reaction to a particular substance, the skin will swell and itch within minutes. The patch test is performed by applying patches containing suspected allergens onto the skin of the back. The patches are removed after 48–72 hours, at which time skin reactions are observed. For these tests, a placebo is administered among other allergens in order to double check results. A blood test (RAST) may also be used to detect IgE.

When people are recognized as allergic in an allergology clinic, doctors treat their symptoms with drugs when it is not possible for them to avoid the allergen. The most common treatment for allergy consists of the administration of cortisone, antihistamines, and allergen immunotherapy, the latter a long-term treatment (three to five years) performed through injections or a sublingual tablet containing the allergen significantly diluted.

THE CAM VERSION

Explicative Model

Orthodox allergists disregard CAM practices and knowledge, although in Italy there are physicians who have a broad understanding of allergy and are sympathetic to its treatment using CAM. In the study area, patients can seek to define, diagnose, and cure their allergies by accessing a great variety of treatments, technologies, and knowledges. An acupuncturist explained that

Allergy is usually a problem involving the energy levels of the lung. The lung governs the skin—as Chinese say—because skin breathes too, it is an organ of, let's say, of transition and is a border between the inside and outside, between the organism and the environment, and so on. Indeed, the skin and lungs stay in a kind of relationship, let's say. . . . The other meridian intervening in allergies is the kidney. The kidney has to do with the function of excretion, the urinary function.

Allergic symptoms, which often include skin problems, emerge when the lung or kidney meridian experience an energy blockage. However, according to an Ayurvedic practitioner:

Ayurveda is divided in categories according to dosha, which means constitutional features. According to dosha, some foods are better metabolized, others worse or not at all It depends on the internal fire, if it is more or less on at a metabolic level, to translate this into scientific terms.

For the Ayurvedic practitioner, allergies were caused by the ingestion of substances not corresponding to individual psychophysical features, called *dosha*.

Most CAM principles and practices endorsed an ecologic perspective. Italian CAM practitioners considered pollution to be a major cause of allergic conditions, with changes in food production and consumption, and air quality, contributing to the prevalence of allergy. Dr. Zanna, a general practitioner who, after graduation, specialized in various CAM therapies including homeopathy and iridology, explained:

Our body has been overloaded with air pollution, pollution of what we eat, drink, touch, and what we think too. Pollution is everywhere and it is normal that people develop symptoms like those of allergies. I simply rebalance people's bodies in order to heal their dysfunctionalities. Then, I act to

strengthen people's defense against continuous aggression from the environment: chemicals, additives, fumes. . . . Because even if people can avoid many pollutants through diet and lifestyle modification, all the things that I prescribe, even then, they cannot escape contact with some kinds of pollution, because nowadays it is everywhere.

Diagnosis and Treatment

Depending on the specific modality, practitioners measured the impact of a substance on the patient by different techniques: by a technological artifact, by the practitioner's perception of the patient's decreased strength, by reading signs on the iris, by the diminished thickness of the patient's energetic field, or other means. Treatments included inserting needles into the patient's skin, prescribing globules with energetic vibrations, absorbing negative energies through the hands, prescribing medicaments, giving injections, using imagination and verbalization techniques, and adjusting spines.

Gianni, a pranotherapist, explained to me that his way of working consisted of 'feeling' the person's aura and putting his hands near the patient's body without touching it. At a preliminary stage, the thickness of the aura gives him an idea of the person's general state of health. If his or her general well-being is undermined, Gianni then starts to explore if there is some external substance that can provoke imbalances. Gianni asks the patient to think about or to touch a particular substance, and in this process, he feels with his hands possible variations in the aura's thickness. In this way, he can identify which substance(s) should be avoided. He may prescribe a diet, but at the same time, he would try to eliminate negative energies from the patient's aura. Gianni's hands surround the patient, he concentrates, and then he makes quick and energetic gestures toward a basin full of salty water on the floor. He removes the negative vibrations from the patient to his hands, and from his hands to the salty water, considered able to absorb negative energies.

Dr. Rossi has a medical background and, subsequently, she was trained in several different CAM specialties. She usually uses verbalization techniques for allergy. Initially she puts a substance suspected of causing the allergic reaction in one hand of the patient. She rests the patient's other hand against her own upright hand, and asks the patient to press against her hand. With this technique, she can identify which substance has been used to shadow an emotional distress, because it is not the substance itself but the association that creates the problem. She asks the patients what allergy means to them. Their answer does not correlate with the disease, but she considers the structure of the discourse and the words chosen as a key to understanding how they have created their physical discomfort. According to her, the symptoms of allergy usually develop as a reaction to an emotional shock. She might then ask the patient to hold the offending substance, and at the same time to visualize a natural element such as a snowflake or sea water. At this point, patients have to feel their bodily reaction, staying for a while with these positive feelings, and then to imagine walking freely and happily through the time line from the present to the future. In this way, she deactivates the negative meaning associated with the offending substance.

The body's overall status is at the core of CAM treatments. CAM practitioners pay particular attention to the body's own defenses, which they regard as an important sign to understand the cause of symptoms. A doctor using a mixed approach explained that he looks at how much an

individual is able to bear stress; the robustness of the person can be a bodily predisposition, but also mind, psyche, and emotions can all be called into play:

The person is showing uneasiness in the capacity to relate to life, with others, with people, with the environment. The person has been overwhelmed. The relationship should be open, where what arrives is comprehended, accepted, and integrated. This is a healthy person Instead, in the case of the allergic person, when something arrives there is a violent reaction, even before its riskiness is evaluated, because the person is . . . is in difficulty. The person hasn't developed the capacity to be in a relationship with any encounter.

External conditions are considered only as a contingent trigger of the emergence of symptoms, so the remedy is to fortify body's power of defense.

MULTIPLICITY MADE SIMPLE

The ways in which practitioners explain, diagnose, and cure allergy vary and might be, at times, confusing. As other studies have shown (Benoit 1993; Krause 2006; Massé 1997; Ohnuki-Tierney 1984; Romanucci-Ross 1977; Rhodes 1980), patients often emphasize the complementarities between different medicines to create a harmonic whole. In Italy, patients simplify multiplicity by dividing health practices into two main categories: *natural* and *non-natural* treatments. The main variable used to determine the membership of a treatment to one group or another is the extent to which it is 'natural.' The choice of a particular CAM treatment over another is contingent and relational. People are often recommended to particular healers by their 'therapy network' (Krause 2008:246) of relatives and friends. Others consume CAM as a commodity: they try a new modality, which by serendipity captures their attention (being located near to their home or office, or being advertised). I define these processes as a socialization of commodities.

Research participants, if asked to explain the concepts underpinning the CAM practices they used (for example, what is a meridian, or how homeopathy works) gave vague answers. I asked Chiara, who consulted a doctor who practices Ayurveda, about chakra:

Well, she [the doctor] explained that to me, but at the moment I am not sure. . . . I do not exactly remember. It has to do with . . . with the specific particularity of every person. Anyway, you know, they are all ideas that respect the body, you heal following the body and not vice-versa, as with normal medicine. Ayurveda, it's all natural.

CAM's perceived value is its naturalness: this is the paramount and enduring idea that remains in people's minds. CAM does not explode into multiple logics: the principle of naturalness underpins the binary opposition of biomedicine and CAM.

I met Manuela—a housewife in her thirties—in the hospital. She suffered from frequent, intense sneezing throughout the day. Her husband urged her to have biomedical treatment, but she was eager to try 'natural medicine' first because of the (assumed) absence of side effects. When I asked to her what she meant by 'natural medicine,' she explained:

Like . . . like acupuncture, homeopathy . . . you know, something that is not a medicine, something that is natural . . . (*laugh*), yes, that is not harmful. Usually doctors give you not-natural stuff.

Manuela opposed biomedicine to ‘natural medicines.’ Natural medicines were, according to her, a single group of medicines without side effects.

Paola, a nursery school teacher in her forties, was able to choose her treatment freely. She explained how she had tried various therapies to cure bothersome eczema on her hands. She narrated with ease her swinging from homeopathy to pranotherapy, meditation techniques, iridology and acupuncture. She described this intricate medical itinerary as “uncomplicated”:

No . . . I don’t find any contradiction because they all are natural methods, I put them all together, so I . . . even if there were one more natural method to help me, I would try it, but if they tell me to have surgery or an injection of a pharmaceutical . . . I would rather stay sick.

Paola was not concerned about the differences in the various practices; rather, she reiterated the difference according to the category of ‘natural medicines.’

Despite the differences in trajectories and practices, all these people arrived at the same conclusion: the attribution of naturalness was significant enough to contain the relative differences among diverse medical traditions and techniques. They superimposed the classificatory logic of naturalness on multiple different natural medicines and modalities, in contrast to non-natural (biomedical) ones.

FACETS OF NATURALNESS

While scholarly debates about the concept of naturalness are ongoing (Ingold 2011:19), preference for natural foods and treatments was widespread among research participants. This is an important element in the success of CAM, especially in the treatment of allergy where one of the popular explanations for its rise has been a departure from the natural to chemical, synthetic products and polluted environments.

Recognizing Pollution

Interpretations and self-diagnosis of allergy were multifactorial: from pollution to stress, genetic factors, life-style changes, psychological problems, weakened immune system, bad luck, menstruation, or mere medicalization. These themes were combined in different ways by different people, but one factor was persistent and recurrent: pollution. All research participants except for one described pollution as the main cause of the emergence of allergy. Pollution, in the words of my informants, was perceived as a non-natural state, typically described in terms of the physical environment (and so, water, earth, and air) and food:

I think we are all allergic because there are too many noxious substances in the environment, in the car . . . on the road, all the burnt fuel. . . . I don’t think it’s properly healthy. . . . I think that a great deal of it is caused by industries . . . all these chemicals . . . all those preservatives, colorings, all those things . . . probably the organism has to . . . it has big difficulties trying to adapt . . . to assimilate all of this, I think. (Mario)

Explanations varied “because all the pollutants are particulates, particles, radio waves” (Giorgio); “they [allergies] are caused by the nuclear bomb, by bombs that launch all the toxic

substances that reach us” (Daniela). Although explanations took on interesting forms, pollution as a broad category remained central to the narratives of people with allergies.

Roberto was in the Unit because his eyes swell significantly when he eats certain things. He told me that increasing numbers of people suffer from allergy because “the world goes on this way.” I asked him what he meant, and he replied:

I believe that organisms, human bodies are slowly adapting to this progress which was not present a hundred years ago. All these chemicals, all these preservatives, coloring, all those things. Organisms have to . . . they have big difficulties to assimilate them, I think. And the . . . then, the families of the past aren't here anymore, we no longer have the great love [in families] that was there in our parents' times. I think infancy is a fundamental part of a person's life. But when one hasn't . . . parents are working away from home, children are at home. I mean, there are cons to modern society, and I think they [allergies] are linked a bit to this.

Roberto's distress included the environment, people, and society, in both material and social-affective dimensions. Roberto jumped quite abruptly from chemicals to families because, according to him, pollution and progress were part of an explanatory model that made sense of complex social and material transformations.

The 'Naturally' Healthy Body

People with allergies believed that their symptoms were provoked by a vulnerable immune system:

Because we have fewer defenses, we are more vulnerable, that is, weaker, and therefore more easily attacked. (Michele)

So . . . I have had a history of allergies since I was expecting my fourth baby. I think my immune defenses were lowered. . . . I was waking up in the morning covered in a rash. (Silvia)

In contrast to CAM explanations of allergy, biomedicine considers allergic bodies as over-reactive. Essentially, both doctors and patients were referring to the same thing, but they defined it from two different perspectives (Raffaetà 2012). For patients, allergy was a debilitating condition that undermined their well-being. People believed that CAM could help to fortify a weak body, because CAM therapies would stimulate intrinsic defenses. Anita, an elegant woman in her fifties with a skin rash, explained:

I have used homeopathy since I was 25, since my first child. I would never ever change this for anything in the world, and now that I have this allergy, it has helped me a lot. Because homeopathy helps you to become stronger, to face adversities with protection because it is all natural. I only believe in energetic vibes. Drugs [biomedical drugs], instead, are part of the problem, they make your body weaker and more intolerant to . . . everything, because they are full of chemicals. You would certainly have heard how many people are allergic to drugs. They make you worse and they should be the last thing to take in case of allergy.

Anita explained that homeopathy was able to strengthen your defenses because the approach involves energetic 'vibes,' which she considered to be a natural component. Vibes are Anita's interpretation of how homeopathy works. Homeopathic drugs are produced by the serial dilution

of a remedy, which have to be appropriate for an individual's symptoms, until there is no trace of pharmacologically active molecules.

Biomedical drugs, instead, are perceived as part of the problem because they are made by chemicals, which, in turn, sensitize the body. Cortisone and antihistamines to alleviate or prevent an allergic response are considered by people to be non-natural treatments:

I used to be a healthy man, to be fine. But then I started to feel bad, my throat and my eyes were swelling when I was eating. I did not know what to do. I did a lot of visits and then I came here, it is ten years now, and I did all the tests. . . . Dr. Ferrari gave me cortisone. I don't know if that's the reason, but since then I haven't been the same. Cortisone gave me side effects, I am sure. Now I am not allergic anymore but I have other problems: for sure I am not the same as I was once. (Lucio)

Biomedical drugs were described as an additional source of toxic exposure, worsening the fragile state of the body. Allergies and biomedical drugs were often associated in people's narratives:

We have less strength to fight what comes from outside, what might be harmful. Maybe immune defenses more . . . sensitive to . . . I do not know . . . probably by always taking a certain medication I got to inhibit a part . . . in the organism . . . in the body, and then it is hit exactly at its most sensitive point. (Maria)

Maria suggested that biomedical drugs increase the body's vulnerability because they contain chemicals, which undermine the body's so-called natural state. CAM drugs, in opposition, are described as natural because they maintain or enhance the original bodily state and composition. This state is never explicitly explained. It remains mythical as much as undefined: an indeterminate ideal.

DISCUSSION

Italian Medical Pluralism

The way in which CAM is perceived and used in Italy is linked to the local history of medical pluralism. Until the early twentieth century, folk medicine—largely based on Greek humoral medicine (Whitaker 2008) and belief in supernatural forces and the evil eye (*malocchio*)—was used widely and coexisted with biomedicine (de Martino 1948, 1961, 1987 [1959]; Romanucci-Ross 1997 [1986]). However, soon after Italian unification (in 1861) and through the fascist era (until 1945), in the name of scientific progress, the Italian government actively opposed folk healing as a set of superstitious and backward practices (Pizza 2005:155; Seppilli 1983, 1989, 2012).

In the second half of twentieth century, as other European countries, Italy embraced a “new medical pluralism” (Cant and Sharma 1999), described as a structured and state-led system of medical legal provision. Since 1991, CAM use in Italy has doubled (Menniti-Ippolito et al. 2002). Italian folk medical concepts reemerged in this process, not including beliefs in supernatural powers. Yet these beliefs persisted, even if highly stigmatized: *Striscia la Notizia*, a popular television program broadcast every evening, constantly shames people who seek healing through supernatural forces. Humoral components of Italian folk medicine, instead, with their philosophic understanding of the interrelationship between body and environment, were most

frequently incorporated into contemporary CAM practice. In this transition, humoral ideas were evoked by an emphasis on ideas of naturalness and pollution rather than concepts of hot and cold (for a similar process of translation of humoral ideas in modern Java, see Ferzacca 2001).

Baer (2001) has observed that in the United States, biomedicine remains hegemonic and CAM is incorporated in ways that sustain biomedical dominance. Medical pluralism has been defined a “myth” (Han 2002), which creates the illusion of choice when, in fact, it reproduces capitalist, biomedical, and bourgeois worldviews. The recognition of medical diversity, it has been argued (Crandon-Malamoud 1991; Kapferer 1983), depends on moral and political issues such as race, ethnicity, and class. Brodwin (1996) considered medical pluralism as the outcome of the complex interplay of moral, political, and clinical issues. CAM is thus an extension of consumerism: drugs become commodities on sale (Nichter 1980), with their exotic origins perceived as providing added value (see Parkin 1968; Rekdal 1999; Whyte 1988).

The Italian context partly supports these observations. The supernatural component of folk medicine has been eliminated, a reflection of middle-class constructions of what counts as medical knowledge. Other CAM modalities are subject to a state-led process of regulation: doctors with a formal biomedical education can practice CAM only as private consultants;¹ CAM is packaged as an exotic commodity with a biomedical imprimatur. Meanwhile, CAM’s potential alterity is assimilated within traditional understandings of body and health.

Yet the Italian case offers insights into medical pluralism. CAM mass consumption has led to the revitalization of traditional and alternative understandings of health and illness (Crandon-Malamoud 2003; Lock 1984); narratives of naturalness are deployed both by Italian CAM practitioners and their patients. CAM in Italy has not been interpreted simply according to local meanings of the body and health (Barnes 1998; Frank and Stollberg 2004; Hare 1993; Hsu and Hoeg 2002; Stollberg and Hsu 2009); resorting to CAM is a way for people to affirm an “alternative modernity” (Hsu 2009; Knauff 2002), asserting traditional values and understandings within a modern framework.

Naturalness is a crucial concept in Italian discourses on allergy: a healthy and natural body is almost an archetypal feature of humanity. Meanings, however, are not simply beliefs that people carry around in their heads: when embodied and anchored to socio-political relations, they affect reality. Theories of embodiment consider the body as the existential ground of culture (Csordas 1990): meanings have to be searched not in formal knowledge but in the way they are lived in specific bodies. Narratives of allergies, moreover, show how body concepts are closely related to ecological experiences, implying the interrelationship of body, culture, and environment (Fletcher 2005; Hsu 2007; Raffaetà 2012) and illustrating how these dimensions are directly linked to socio-political circumstances (Scheper-Hughes and Lock 1987). Thus, to speak of a ‘natural’ body is to refer to a normative social and moral order.

Nature and Pollution in Italy

Local meanings of health and body give place to daily practices to maintain a state of equilibrium between the body and its environment (Whitaker 2008:348). The body is perceived as fragile, constituting a precarious boundary against threatening environmental assaults (Raffaetà 2012). The differentiation between natural and polluted substances sits at the core of daily practices of hygiene and care, observed to avoid contamination. This distinction—between

natural/good and polluted/bad—determines why CAM practices are grouped into a meaningful whole. Biomedical advice, too, is subsumed under popular understandings, creating an indigenous process of medicalization (Raffaetà 2011a). Popular explanations of allergy, for example, refer to concepts of pollution and the body's permeability. These ideas are rejected by allergists.

Pollution plays a particularly dominant role in everyday conversations in Italy, partly because of the relatively recent shift from a rural to industrialized country. Until the end of the Second World War, Italy's economic activities were primarily agricultural and horticultural. The 1950s are still referred to as the years of the *miracolo italiano* (Italian miracle), when Italy was transformed from a country of peasants to an industrialized nation of small- to medium-sized enterprise. The city in which I conducted research, and its surroundings, is located in an area that experienced massive industrial development after the Second World War and is part of a wider industrial network in the northeast. Although a well-known tourist destination, the city hosts various industrial activities, especially manufacturing. Agricultural activities continue too, but they have become industrialized and intensive: small farms have let their land to larger agricultural companies, changing the appearance of the landscape and the ways in which people live. Laborers, traders, service workers, and white-collar workers have replaced peasant farmers and animal breeders. The rivers, once part of the social and economic life of these places, have become polluted and have been abandoned by local residents. A strange smell—a mixture of dung, fertilizer, and fumes—pervades the plains, especially in winter when the fog condenses and fixes this noxious blend.

These changes affect how people live and how they relate to the socio-material environment, creating a kind of nostalgia for a former lifestyle. Concepts of naturalness are widely used, contrasting the invasion of industry with traditional lifestyles and landscapes. Globally, discourses on naturalness are increasingly nuanced by moral connotations; in Italy this is particularly true, for example, with 'natural food' emerging as a distinct alternative to modernization. It is not by chance that Slow Food, an international movement that supports the idea of natural and sustainable food consumption and production, had its birthplace in Italy, a country where memories of the rural past are still sharp (Figure 1).

Not only food but also medicine has taken a moral turn; concepts of naturalness, health, and body have a normative value. Naturalness, as the preservation of a traditional order, pervades Italian perceptions of health, but it also informs more broadly ideals and esthetics of the body. Italian feminine beauty, for example, has been traditionally defined according to how natural it is, without need of make-up or surgery (Gundle 2007). Renaissance beauty remains the ideal, an ancestral splendor closely linked to nature. During the 1950s, the naturalness of Italian women was promoted in contrast to Hollywood stars such as beauty icon Rita Hayworth, in a political attempt to resist American cultural colonization. Gramsci identified the construction of the female body and personality as a major 'permanent cultural activity' of the Italian state (Pizza 2012:98). The prototype of 'natural beauty' supported the media success of women who were presented with an instinctive, primitive, and primordial sensuality linked to a rural world. Actresses as Sofia Loren and Gina Lollobrigida often played the role of hale and hearty peasant women, with generous body shapes and passionate carnality, evoking "nostalgic sentiments of rural lifestyle when gender and class roles were clearly defined" (Gundle 2007:XXXII). In the post-war years, plumpness had a positive connotation, indicating constitutional strength, health, and vitality, in contrast to thinness linked to images of death and disease. Current Italian beauty



FIGURE 1 Mulino Bianco is Barilla's brand of bakery products, biscuits, and snacks, nationally leading in the sector since 1975. The figure (downloaded from <http://www.mulinobianco.it/storia-e-pubblicita>) illustrates the centrality of images of naturalness and of a rural past for Italians. Core images have been maintained and adapted to the needs of specific decades: in the current version, the rural landscape has a fairytale ambience. See <http://www.mulinobianco.it/storia-e-pubblicita/la-comunicazione/2000-11/la-vita-e-una-favolacentral> (color figure available online).

icons like Manuela Arcuri and Mariagrazia Cucinotta are ambivalent: their thinner body profiles speak to international standards of beauty, while their full breasts retain traditional aesthetic canons. The reassuring fixity of gender roles is expressed through women's stereotypical appearance: they come to embody the benevolent 'Mother Nature.' The rural past is embraced as an iconographic symbol of virtue, removing negative and unhealthy aspects such as poverty, hunger, inequality, infection, and early mortality.

The idea of 'nature' in relation to CAM is present also in other settings (Connor 2004), but it may be linked to a rather different set of meanings. Kaptchuk and Eisenberg (1998), for example, list nature together with vitalism, science, and spirituality as among the main concepts, which enabled the spread of CAM in the United States. Nature, in the United States in contrast to Italy, takes on both more spiritual and social dimensions: through natural medicines, people feel they can renovate their soul and by belonging to a wider movement, they are contributing to the regeneration of society. For historical reasons, in Italy, the concept of nature has different roots; while in the United States it has a more progressive connotation (Whorton 2002), in Italy it is an encounter with the past.

Naturalness in Italy is a pervasive concept, which links conceptions of health to morality, politics, and esthetics. Pollution, chemicals, and Rita Hayworth are all actors coming from a foreign modernity, which weaken traditional (and so-called natural) certainties and bodies. Naturalness permits people to derive an ethic from an esthetics: it is a latticed concept (Parkin 1995), which attracts elective affinities² (Johannessen and Lazar 2006; Lyng 1990) between biomedicine, cultural, and political structures.

Naturalness is a social construction complementary to the concept of pollution, individuated as one of the main causes of people's symptoms. As Mary Douglas (1975; Douglas and Wildavsky 1982) showed long ago, the concept of pollution, beyond local characterizations, is a crucial anthropological category used to determine what stays outside a society's moral and social order. Douglas's seminal ideas were applied to analyze environmental risks as specific

socio-political constructions (Lash, Szerszynski, and Wynne 1996; Litfin 1994; Milton 1993; Pidgeon, Kasperson, and Slovic 2003), against a realist approach that considered environmental risks to be a consequence of modernization and technology (Beck 1992 [1986], Beck 1995; Giddens 1990).

In my research, interviewees, however, do not simply refer to risks; they speak about uncertainty. The loss of stable reference points, and their anxiety about contamination from pollutants, makes the notion of risk outdated (Callon, Lascoumes, and Barthe 2001; Wynne 1996): environmental risks are not fully calculable because various scenarios are possible for complex problems. To face an uncertain present, Italians romanticize the past, and valorize fixed gender roles, folk wisdom, and socio-biological authenticity.

CONCLUSION

I have described how people use CAM and/or biomedicine to treat their allergies and how these perceptions are interwoven with the knowledge and techniques of various practitioners. Some doctors speak of chakra, others of meridians, immune system antibodies, iris, aura, soul, or spine. Some prescribe biomedical drugs, other insert needles in the skin, superimpose hands, prescribe drops with energetic vibes, or recommend diets, prayers, or herbs. Patients do not get lost in this multiplicity.

The complexity created by the coexistence of multiple medical practices might appear confusing from an etic perspective, but from patients' perspectives, things are simpler. They create two groups: natural (CAM) and non-natural medicines (biomedicine). The meaning of naturalness is superimposed on different elements. It unifies multiple modalities under the one umbrella. In consequence, pluralism is made manageable; pluralism of modalities does not correspond to the effective pluralism of meanings. But because biomedicine is not a universal set of practices and knowledge, there is no objective way to define medical pluralism. In the rush to uncover hegemonic powers, the risk is to assume too readily that what is termed as 'medical pluralism' is already firmly defined. But for people in the study setting, medical pluralism does not describe a set of bounded medical systems and exclusive practices. Rather, medical pluralism captures local entanglements with power relations (between CAM and biomedicine), the historical context, and cultural assumptions.

The value of pluralism does not simply lie in the number of available options but in how strongly these are embedded in *lively meanings*. Meanings pertain to the cultural domain, but they are not fictional: the cultural is enmeshed into specific practices and relations. Established meanings do not need extra 'boundary work' (Gieryn 1983; Mizrahi, Shuval, and Gross 2005) to protect a specific cultural domain. CAM's assimilation within local meanings explains its vitality and renders CAM an open platform (see Keating and Cambrosio 2000) for experimentation and syncretism. In a field of unequal forces, where equity among epistemologies is lacking, the grouping of CAM around a deep-layered meaning (for example, of naturalness) allows for the expression of diversity and syncretism. The 'ideal type pluralism' (Cant and Sharma 1999:4) is a mirage, and locally-suited solutions provide opportunities for healers and patients to nuance biomedicine with different practices and to experience therapy as an open platform.

ACKNOWLEDGMENTS

I would like to thank Lenore Manderson for her precious work of sharpening and editing the article and for her intellectual generosity in supporting my writing experimentations in a foreign language. I would also like to thank the kind treatment I received by the hospital medical staff and, finally, my Italian colleagues, Giovanni Pizza and Ivo Quaranta, for having encouraged me to undertake the research path at the end of my undergraduate studies. The paper derives from PhD research, which was funded by Vaud Academic Society (2008), the Italo-Suisse Foundation (2007), the Italian Ministry for Foreign Affairs (2005–2006), and its writing was supported by the European Community and Provincia Autonoma di Trento through the fellowship Marie Curie COFUND 2009—Reintegration—project “Trentino”—The Trentino programme of research, training and mobility of postdoctoral researchers.

NOTES

1. Ten Italian regions have regional regulations integrating various CAM practices within the public health care system, allowing people the opportunity to access CAM with no or limited cost. The region in which I conducted the study does not provide CAM within the public sector, although since completing the study, new legislation has been proposed at the national level, which is still subject to final parliamentary approval.

2. The term, originally used in chemistry, has entered social science literature to account for a relation between two different social dimensions.

REFERENCES

- Baer, H. A.
2001 *Biomedicine and Alternative Healing Systems in America: Issues of Class, Race, Ethnicity, & Gender*. Madison: Wisconsin University Press.
- Barnes, L. L.
1998 The psychologizing of Chinese healing practices in the United States culture. *Medicine and Psychiatry* 22(4):413–443.
- Beck, U.
1992 [1986] *Risk Society: Towards a New Modernity*. London: Sage.
- _____.
1995 *Ecological Politics in an Age of Risk*. Cambridge, UK: Polity Press.
- Bielory, L.
2002 ‘Complementary and Alternative Medicine’ population based studies: A growing focus on allergy and asthma. *Allergy* 57(8):655–658.
- Benoist, J.
1993 *Anthropologie Médicale in Société Créole*. Paris: Presses Universitaires de France.
- Brodwin, P.
1996 *Medicine and Morality in Haiti*. Madison: University of Wisconsin Press.
- Callon, M., P. Lascoumes, and Y. Barthe
2001 *Agir Dans un Monde Incertain. Essai sur la Démocratie Technique*. Paris: Seuil.
- Cant, S. and U. Sharma
1999 *A New Medical Pluralism? Alternative Medicine, Doctors, Patients and the State*. London: UCL Press.
- Clarke, A.
2005 *Situational Analysis: Grounded Theory After the Postmodern Turn*. Thousand Oaks, CA: Sage.

- Connor, L. H.
2004 Relief, risk and renewal: Mixed therapy regimens in an Australian suburb. *Social Science & Medicine* 59(8):1695–1705.
- Crandon-Malamoud, L.
1991 *From the Fat of Our Souls: Social Change, Political Process, and Medical Pluralism in Bolivia*. Berkeley: University of California Press.
-
- 2003 The effects of modernization on mestizo medicine in rural Bolivia: The case of two Mestizo sisters. *In Medical Pluralism in the Andes*. J. D. Koss-Chioino, T. Leatherman, and C. Greenway, eds. Pp. 27–41. London and New York: Routledge.
- Csordas, T.
1990 Embodiment as a paradigm for anthropology. *Ethos* 18(1):5–47.
- de Martino, E.
1948 *Il Mondo Magico*. Torino, Italy: Universale Scientifica Boringhieri.
-
- 1961 *La Terra del Rimorso. Contributo a una Storia Religiosa del Sud*. Milano, Italy: Il . . . Saggiatore.
-
- 1987 [1959] *Sud e Magia*. Milano, Italy: Feltrinelli.
- Douglas, M.
1975 Environments at risk. *In Implicit Meanings*. M. Douglas, ed. Pp. 230–248. London: Routledge.
- Douglas, M. and A. Wildavsky
1982 *Risk and Culture. An Essay on the Selection of Technological and Environmental Dangers*. Berkeley: University of California Press.
- Ferzacca, S.
2001 *Healing the Modern in a Central Javanese City*. Durham, NC: Carolina Academic Press.
- Fletcher, C.
2005 Dystoposthesia. Emplacing environmental sensitivities. *In Empire of the Senses. The Sensual Culture Reader*. D. Howes, ed. Pp. 380–396. Oxford, UK and New York: Berg.
- Frank, R. and G. Stollberg
2004 Conceptualizing hybridization. On the diffusion of Asian medical knowledge to Germany. *International Sociology* 19(1):71–88.
- Giddens, A.
1990 *The Consequences of Modernity*. Cambridge, UK: Polity Press.
- Gieryn, T. F.
1983 Boundary-work and the demarcation of science from non-science: Strains and interests in professional interests of scientists. *American Sociological Review* 48(6):781–795.
- Gundle, S.
2007 *Figure del Desiderio. Storia della Bellezza Femminile Italiana*. [Eng. ed: *Bellissima. Feminine beauty and the idea of Italy*.] Roma: Laterza.
- Han, G. S.
2002 The myth of medical pluralism: a critical realist perspective. *Sociological Research Online* 6(4). <http://www.socresonline.org.uk/6/4/han.html>, accessed December 17, 2012.
- Hare, L. M.
1993 The emergence of an urban US Chinese medicine. *Medical Anthropology Quarterly* 7(1):30–49.
- Hsu, E.
2007 The biological in the cultural: The five agents and the body ecologic in Chinese medicine. *In Holistic Anthropology. Emergence and Convergence*. D. Parkin and S. Ulijaszek, eds. Pp. 91–126. New York and Oxford, UK: Berghahn Books.
-
- 2009 Chinese propriety medicines: An ‘alternative modernity?’ The case of anti-malarial substance artemisinin in East Africa. *Medical Anthropology* 28(2):111–140.
- Hsu, E. and E. Hoeg
2002 Countervailing creativity: Patient agency in the globalisation of Asian medicines. *Anthropology & Medicine* 9(3):205–221.

- Ingold, T.
2011 *Being Alive. Essays on Movement, Knowledge and Description*. London and New York: Routledge.
- Janesick, V. J.
1994 The dance of qualitative research design: Metaphor, methodolatry and meaning. *In Handbook of Qualitative Research*. N. K. Denzin and Y. S. Lincoln, eds. Pp. 209–219. Thousand Oaks, CA: Sage.
- Johannessen, H. and I. Lazar, eds.
2006 *Multiple Medical Realities: Patients and Healers in Biomedical, Alternative and Traditional Medicine*. New York: Berghahn Books.
- Johansson, S. G. O., J. Hourihane, J. Bousquet, C. Bruijnzeel-Koomen, S. Dreborg, T. Haahtela, M. L. Kowalski, et al.
2001 A revised nomenclature for allergy: An EAACI position statement from the EAACI . . . nomenclature task force. *Allergy* 56(9):813–824.
- Kapferer, B.
1983 *A Celebration of Demons: Exorcism and the Aesthetic of Healing in Sri Lanka*. Bloomington: University of Indiana Press.
- Kaptchuk, T. J. and D. M. Eisenberg
1998 The persuasive appeal of alternative medicine. *Annals of Internal Medicine* 129(12):1061–1065.
- Keating, P. and A. Cambrosio
2000 Biomedical platforms. *Configurations* 8(3):337–387.
- Knafli, K. A. and B. J. Breitmayer
1991 Triangulation in qualitative research: Issues of conceptual clarity and purpose. *In Qualitative Nursing Research: A Contemporary Dialogue*. J. M. Morse, ed. Pp. 135–148. Newbury Park, CA: Sage.
- Knauff, B.
2002 Critically modern: An introduction. *In Critically Modern: Alternatives, Alterities, Anthropologies*. B. Knauff, ed. Pp. 1–56. Bloomington: Indiana University Press.
- Krause, K.
2006 “The double face of subjectivity”: A case study in a psychiatric hospital (Ghana). *In Multiple Medical Realities*. H. Johannessen and I. Lazar, eds. Pp. 54–71. New York and Oxford, UK: Berghahn Books.
- _____
2008 Transnational therapy networks among Ghanians in London. *Journal of Ethnic and Migration Studies* 34(2):235–251.
- Lash, S., B. Szerszynski, and B. Wynne, eds.
1996 *Risk, Environment & Modernity. Towards a New Ecology*. London: Sage.
- Litfin, K. T.
1994 *Ozone Discourses. Science and Politics in Global Environmental Cooperation*. New York: Columbia University Press.
- Lock, M.
1984 *East Asian Medicine in Urban Japan: Varieties of Medical Experience*. Berkeley: University of California Press.
- Lyng, S.
1990 *Holistic Health and Biomedical Medicine—A Counter-System Analysis*. New York: State University of New York Press.
- Massé, R.
1997 Les mirages de la rationalité des savoirs ethnomédicaux. *Anthropologies et Sociétés* 21(1):53–72.
- Menniti-Ippolito, F., L. Gargiulo, E. Bologna, E. Forcella, and R. Raschetti
2002 Use of unconventional medicine in Italy: a nation-wide survey. *European Journal of Clinical Pharmacology* 58(1):61–64.
- Miles, M. B. and A. M. Huberman
1984 *Qualitative Data Analysis: A Sourcebook of New Methods*. New York: Sage.
- Milton, K., ed.
1993 *Environmentalism. The View from Anthropology*. London: Routledge.
- Mizrachi, N., J. T. Shival, and S. Gross
2005 Boundary at work: Alternative medicine in biomedical settings. *Sociology of Health and Illness* 27(1): 20–43.

- Mol, A.
1999 Ontological politics. A word and some questions. *In* Actor Network Theory and After. J. Law and J. Hassard, eds. Oxford, UK: Blackwell.
- Morse, J., M. Barrett, M. Mayan, K. Olson, and J. Spiers
2002 Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods* 1(2):13–22.
- Nichter, M.
1980 A layperson's perception of medicine as perspective into utilization of multiple therapy systems in the Indian context. *Social Science & Medicine* 14B(4):225–233.
- Ohnuki-Tierney, E.
1984 *Illness and Culture in Contemporary Japan. An Anthropological View*. Cambridge, UK: Cambridge University Press.
- Parkin, D.
1968 Medicines and men of influence. *Man* 3(3):424–439.
- _____
1995 Latticed knowledge: Eradication and dispersal of the unpalatable. *In* *Islam, Medicine and Anthropological Theory. Counterworks: Managing the Diversity of Knowledge*. R. Fardon, ed. Pp. 143–164. London: Routledge.
- Pidgeon, N., R. E. Kasperson, and P. Slovic
2003 *The Social Amplification of Risk*. Cambridge, UK: Cambridge University Press.
- Pizza, G.
2005 *Antropologia Medica. Saperi, Pratiche e Politiche del Corpo*. Roma: Carocci.
- _____
2012 Second nature: on Gramsci's anthropology. *Anthropology & Medicine* 19(1):95–106.
- Raffaetà, R.
2011a The allergy epidemic, or when medicalisation is bottom-up. *In* *On Bodies and Symptoms. Anthropological Perspectives on Their Social and Medical Treatment*. S. Fainzang and C. Haxaire, eds. Pp. 59–77. Tarragona, Spain: URV Publications.
- _____
2011b Understanding allergy: A review of relevant studies. *Curare. Zeitschrift für Ethnomedizin—Journal of Medical Anthropology* 34(3):182–192.
- _____
2011c *Identità compromesse. Malattia e Cultura: Il Caso dell'Allergia*. Milano, Italy: Ledizioni.
- _____
2012 Conflicting sensory relationships. Encounters with allergic people. *Anthropology & Medicine* 19(3):339–350.
- Rekdal, O. B.
1999 Cross-cultural healing in East African ethnography. *Medical Anthropology Quarterly* 13(4):458–481.
- Rhodes, L.
1980 Movement among healers in Sri Lanka: a case study of a Sinhalese patient. *Culture, Medicine and Psychiatry* 4(1):71–92.
- Romanucci-Ross, L.
1977 The hierarchy of resort in curative practice: The Admiralty Islands, Melanesia. *In* *Culture, Disease, and Healing: Studies in Medical Anthropology*. D. Landy, ed. Pp. 481–487. New York: MacMillan.
- _____
1997 [1986] Creativity in illness: Methodological linkages to the logic and language of science in folk pursuit of health in Central Italy. *In* *The Anthropology of Medicine: From Culture to Method*. L. Romanucci-Ross, D. E. Moerman, and L. R. Tancredi, eds. Pp. 5–18. Westport, CT: Bergin and Garvey.
- Sandelowski, M.
1993 Rigor or rigor mortis: the problem of rigor in qualitative research revisited. *Advances in Nursing Science* 8: 27–37.
- Schäfer, T.
2004 Epidemiology of complementary alternative medicine for asthma and allergy in Europe and Germany. *Annals of Allergy, Asthma & Immunology* 93(2):S5–S10.

- Scheper-Hughes, N. and M. Lock
 1987 The mindful body. A prolegomenon to future work in medical anthropology. *Medical Anthropology Quarterly* 1(1):6–41.
- Senna, G., P. Bonadonna, M. Schiappoli, G. Leo, C. Lombardi, and G. Passalacqua
 2005 Pattern of use and diagnostic value of complementary/alternative tests for adverse reactions to food. *Allergy* 60(9):1216–1217.
- Seppilli, T.
 1983 La medicina popolare in Italia. Special Issue, *La Ricerca Folklorica* 8:3–6.
-
- 2012 Itineraries and specificities of Italian medical anthropology. *Anthropology & Medicine* 19(1):17–25.
- Seppilli, T., ed.
 1989 *Le Tradizioni Popolari in Italia*. *Medicine e Magie*. Milano, Italy: Electa.
- Smith, J.
 1993 *After the Demise of Empiricism: The Problem of Judging Social and Educational Inquiry*. Norwood, NJ: Ablex.
- Sparks, A. A.
 2002 Myth 94: Qualitative health researchers will agree about validity. *Qualitative Health Research* 11(4):538–552.
- Stollberg, G. and E. Hsu
 2009 Introductory note. *Medical Anthropology* 28(2):109–110.
- Strachan, D.
 1989 Hay fever, hygiene and household size. *British Medical Journal* 299(6710):1259–1260.
- Tobin, G. A. and C. M. Begley
 2004 Methodological rigour within a qualitative framework. *Journal of Advanced Nursing* 48(4):388–396.
- von Mutius, E., C. Fritzsche, S. K. Weiland, G. Röhl, and H. Magnussen
 1992 Prevalence of asthma and allergic disorders among children in united Germany: A descriptive comparison. *British Medical Journal* 305:1395–1399.
- Wainwright, D. Can social research be qualitative, critical and valid? *The Qualitative Report* 3(2):2.
- Wardlaw, A.
 1995 Air pollution and allergic disease: Report of a working party of the British Society for Allergy and Clinical Immunology. *Clinical and Experimental Allergy* 23(3):6–8.
- Whitaker, E. D.
 2008 The idea of health: History, medical pluralism, and the management of the body in Emilia-Romagna, Italy. *Medical Anthropology Quarterly* 17(3):348–375.
- Whittemore, R., S. K. Chase, and C. Mandle
 2001 Validity in qualitative research. *Qualitative Health Research* 11(4):522–537.
- Whorton, J. C.
 2002 *Nature Cures. The History of Alternative Medicine in America*. New York: Oxford University Press.
- Whyte, S. R.
 1988 The power of medicines in East Africa. In *The Context of Medicines in Developing Countries*. S. Van der Geest and S. R. Whyte, eds. Pp. 217–233. Dordrecht, The Netherlands: Kluwer.
- Wynne, B.
 1996 May the sheep safely graze? A reflexive view of the expert-lay knowledge divide. In *Risk, Environment & Modernity. Towards a New Ecology*. S. Lash, B. Szerszynski and B. Wynne, ed. Pp. 44–83. London: Sage.