Jan Hendrik van den Berg

About phenomenology, historical psychology and medical anthropology

Jacques De Visscher

The Dutch psychiatrist Jan Hendrik van den Berg is the founder of 'Metabletica', the study of historical synchronic cultural developments that mark the expansion of civilization because they bring decisive changes. The phenomenological method is deeply central to Metabletica because it takes phenomena seriously that appear to our pre-reflexive consciousness. These phenomena are the starting point of the anthropological understanding of mankind as 'being-in-the-world'. This sort of understanding is also fundamental to the clinical observation of any patient, in particular the psychiatric patient. Phenomena are framed in a context where each part forms an allegory of the whole. For example, commanding works of architecture also reveal something about the spiritual and intellectual life of a cultural period and, in turn, the movements in architecture accompany changes in medicine. Van den Berg's Metabletica found its richest application in the study of European spiritual and intellectual development. In the end, the question of what Van den Berg's contribution has been for medical anthropology is addressed.

[culture, phenomenology, historical psychology, psychiatry, medical anthropology]

1

Jan Hendrik van den Berg, who recently died at the age of 98, was trained as psychiatrist and developed an unconventional and highly original perspective on body, sickness and 'mental disorder'. He was a phenomenologist with a sharp eye for sociocultural and historical contexts. But, was he also a (incognito) medical anthropologist, as Van der Geest (2012) suggested in an essay about the beginnings of medical anthropology in the Netherlands? In this brief overview of Van den Berg's work and ideas, I argue that his perspective was indeed closely related to what appeared to be a phenomenological trend in medical anthropology some years later.

2

"All mentally ill people are also human beings. The only difference between the healthy and the sick is that projections, conversions, transferences and memory distortions are not conspicuous in the healthy person but are very much so in the mentally ill. The reason for this is that the healthy person will discover in his healthy fellow human beings the selfsame, or more or less the same, conversions, projections, transferences and distortions of memory as he himself has, whereas the mentally ill person is alone with his mental mechanisms." So writes Jan Hendrik van den Berg, psychiatrist and psychotherapist, in his book on the phenomenological approach to the mentally ill patient (1972: 104-105). For the author, the fact the psychiatric patient feels lost and lonely does not mean that the psychiatrist needs to consider his patients as individuals in the original sense of the word: as isolated, undivided and separated from the environment. Rather his patients are considered as striking representatives of a cultural period and a social environment, as persons *in* and *of* the world. Patients can be seen as translators of what matters in a particular period and a particular society. They express the neurosis-inducing elements that give any civilization its colour and vitality and are the sources of numerous novels and plays, especially about the difficult to accept existential loneliness, inequalities, spiritual disorientation and historical oblivion. In this perspective, neuroses are not isolated personal conflicts that plague the life of a particular patient, but more 'socioses'. Neuroses are socioses because no one is neurotic unless the community has made him neurotic, writes Van den Berg in 1956.

> A neurosis is the individual response to the combined contradictions and complexities that emerge from society. (…) All neurosis-inducing aspects have a communicative and sociological character. No aspect concerns the solitary individual. The individual only becomes neurotic as a result of the neuroticizing appeal addressed to him from the complex social order of which he is a part. That is why the epithet 'neurotic' is no longer correct. (…) The neurotic is not ill as a result of illness generating aspects *in himself*, aspects, in other words, that are enclosed in his own subjectivity, but rather he is ill because of things *outside himself* (1956: 199-201, translation MV).

3

This idea of the 'socioces' has two implications. First, there is the phenomenological assumption of a pleading, demanding exteriority. The external world makes an appeal on our natural intentionality or involvement. And second, there is the assumption that an orientation towards 'the outside' provides the necessary condition for the unfolding of the historical-cultural scope of our way of being. The psychotherapist takes these implications into consideration as he attempts to understand his patient's uniqueness. He does not focus on the unapproachable inner world, but instead concentrates on coming to understand the patient's very distinctive way of being-in-the-world, how he

is with ‘the other’, and how he worries today about things that will or might happen tomorrow. The psychotherapist will not learn much by nudging his patient towards introspection. No, states Van den Berg, he wants to learn how his patient is *in* the world. The human being is always involved in the world; he is a worldly being. This is an essential application of the phenomenological insight that teaches us that we are ‘in-the-world’, and not in our inner self, which is claimed to be an independent entity, the soul. No, for Van den Berg the soul is situated in the world around us. The human being is always and everywhere between heaven and earth. Not in the patient’s head, except when he has a headache. Our consciousness is our involvement in what is outside of ourselves to be taken up by the events, the other human beings and the things outside of us. This same consciousness constitutes phenomena, i.e. the appearances, which emerge against the ‘background’ of the life-world (*Lebenswelt*). This conviction implies that we must be aware of the historical dimension of the phenomena. A human being is always integrated in a biography; a social event is never isolated and the things outside of us are artefacts with a story and a context. As a reader of Husserl’s ‘*Logische Untersuchungen*’ and of Heidegger’s ‘*Sein und Zeit*’ Van den Berg knows that in our perception, things and objects vary in time and space. They change and we are involved in the historical dynamics of these changes. Paying attention to the way things as phenomena appear to us sharpens the attention of every therapist. Observation asks us to stand still to reflect on what happens, what appears to us, and on the fact *that* there is something, and then to see *how it* is.

4

It is impossible to properly value the fundamental anthropological given, derived from phenomenological description, that we are bodies directed at the world outside ourselves. We need to continually find new ways of exploring this elementary insight. In doing so, we also underscore that both things ‘outside’ ourselves and we ourselves *in* this ‘outside’ are continually changing. By observing, exploring, describing again and again what we really (phenomenologically) experience through all the senses, we give both form and witness to the basic insight of the changing reality of human existence.

5

Intentionality is the core of human existence and change is the essential modus of human nature. All our activities are a manifestation of that involvement and a reaction to those changes. This is not only so for the behaviour of a particular human being, but it is also comparable for social phenomena and institutional conduct. The essential characteristic of things-in-the-world, especially our experience of these things, is that they are continually changing. And as a result, those things, in their manifold appearances, communicate important aspects of our state of being to us (without which we would not know who we are). To put it in even stronger terms: we are living in plurali-

ties, in multiplicities. And so, the appearance of things and their contexts may reveal how a society or culture is rooted in a particular historical period.

Psychologists and sociologists are not the only ones to have given meaning to these phenomenological findings. Almost all novels (and later films) that place their characters in a social and geographic contextual situation show the evocative and richly expressive power of metamorphoses. Van den Berg discovered and understood this early in his training. If we want to grasp the perspective of psychiatry, we can not only study psychiatric literature and case descriptions; we must also position psychiatric literature in a specific cultural context, although even that is not enough. Van den Berg ascertained this shortly after the Second World War when he went to Paris to study French psychiatry. In a series of guest-lectures at the University of Leuven, in the fall of 1996, he told the following anecdote.

> As student of Henri Ey, I attended all his lectures in Sainte-Anne, the psychiatric university clinic near the Metro St. Jacques in Paris. In addition, I bought modern and ancient tomes about psychiatry, and read and reread them. But whatever I attempted, I just did not seem to understand French psychiatry, the oldest and most famous of Europe. I worried excessively about this, and felt a deep sense of shame. I was a fully trained psychiatrist-neurologist. In addition, I had earned my PhD by writing a thesis about psychiatry. How was it possible that I could not comprehend French psychiatry?! At a certain point along the Seine that I remember exactly to this day, I was talking about this to a fellow-student. He said, "But mon ami, you are doing it all wrong! You have to understand the French spirit first. Read French literature, easy ones like André Gide, Valerie Larbaud, de Montherlant, Julien Green, and don't forget Jean-Paul Sartre, go attend his plays." I did as he advised. And what I learned then was what I could have known, but somehow didn't, and that is that the French spirit is *perception*, seeing, listening, tasting, smelling. There is a French cuisine and not really a German one, not on the same level. The Frenchman *perceives*, the German *thinks* – although this is probably a little exaggerated. And so the Germanic psychiatry that I had studied in the Netherlands was based on *delusion*, an impairment in thinking. French psychiatry is founded upon *hallucination*, which in this context can be seen as an impairment in perception. And when I understood that, I also had the key to understanding French psychiatric literature (translation MV).

Is it not the same for every discipline – that we need to study the cultural context in which it finds itself? Not every researcher will have the same patience to meet this reality, but for Van den Berg this was a self-evident truth for the human sciences in general, and medicine and psychiatry in particular. In general, we may accept that to understand the thesis that human existence, and consequently the human body, has changed through the ages, we must go back to past centuries and their artistic, cultural, political and scientific artefacts. As Sjaak van der Geest (2012: 12-13) remarks, therefore, Van den Berg develops a "style of reasoning that does not fit in any conventional discipline (…). His argument follows unpredictable associations, from paintings by Brueghel, Rubens and Picasso, to a mystic's vision, a book of devotion, a scientific study of the heart, a paper clipping about the rescue of a drowning person, a

collection of lyrics, an X-ray photograph, and a building by Le Corbusier." From this kaleidoscope of synchronic phenomena I will focus below on Van den Berg's fascination with architecture.

6

With fearless freedom, Van den Berg consults iconographic and literary sources in order to understand the changes in medical practice and scientific knowledge. We find these descriptions in the magisterial two-volume study on the human body ('The open body' and 'The abandoned body'), in which he sets out his own peculiar metabletic vision on the history of anatomy.[1] In this study, he examines the movements in diagnostic observation of the human body caught in the medical gaze, a body that can never be absolutely objectified because it is always caught in a web of significances. It is a body that is the backdrop to the various forms of human dramas, from the body of an infant to that of an elderly person, the body of one who has worked hard all his life, the body of a pin-up model, a sportsman, a cabinet minister under oath, also the body on the dissection table, at the baptismal font, and the body about to be buried. Van den Berg shows again and again that to see and to have a vision are two parts of the same process, that it is impossible to see something without having had a previous image of it in one's mind, and that there is no real knowledge without preceding concepts and imagination. Whoever researches makes himself part of the process. This is the central message of the phenomenologist Van den Berg. In this process, we who are this 'self' that observes and conceptualizes, we are carriers of the history of the culture of which we are a part.

The study of the contextualized body means that in our exclusive analysis of an anatomized body we can only see a disincarnated body, a 'thing-body' (*Körper*) and not a 'lived-body' (*Leib*). We only see a trunk with head and limbs, that is big or little, skinny or not. As soon as we shift our discourse to include observations like attractive, or frighteningly abused, our perception is already under the influence of cultural-historical conditions. We will learn much about the lived body (*Leib*) if we understand the buildings that are built to house this body, their interior design, the history of the bed and clothing, each thing that the body (*Leib*) needs to be a body with humanity. Because in everything we do, we also participate as a body. This insight led Van den Berg to signal a number of synchronicities, for instance that architectural changes can also shed light on changes in medicine in general and psychiatry in particular.

7

"Whoever wants to understand the inner disturbance of temperament, must find a more accessible inner space to study, for example an architectonic space of the same historical time." This is the central tenet of a remarkable lecture held in Utrecht in 1987 at the Association of Philosophy and Medicine, entitled 'Rise and fall of the medical model in psychiatry'. Van den Berg attempts to illustrate that rise and fall

using architectural examples. History taught Van den Berg that the biomedical model – the conviction that spiritual disturbances are illnesses, treatable with physical-chemical interventions just like other illnesses – dates from the end of the 18th century. On the 11th of September 1793, Philippe Pinel, a medical doctor and head of the institution Bicêtre in Paris, made the decision to unshackle the disturbed persons in his care and treat them like other patients. At the same time, in England and Germany analogous decisions and actions were taken, and so this can not be considered solely a coincidence, but rather a synchronistic event, a metabletic occurrence. And again, not coincidentally for Van den Berg, this happened in the wake of the French Revolution. And so he looks at the architecture of the times, or rather he examines extraordinary architectural occurrences or changes that take place in the same time as the origin of the medical model and the French revolution. Van den Berg finds the iconic example in the fate of the Church of St. Genevieve, finished in 1790, but commissioned years earlier by the French king Louis XV in gratitude for recovery from a serious illness. Unfortunately, a church commissioned by a king so immediately after the French revolution is a political and social impossibility, and the building that is the very image of Catholic sensibilities is quickly converted into a temple dedicated to the more human divinities that are heroes of revolution, and becomes the Panthéon (The temple for all the gods). It is a largely empty mausoleum with windows that have been bricked up and has very sober graves in the crypt. Van den Berg sees analogies and synchronistic phenomenologies and cross-currents in this story. In the same way the sacred has been drained from the Panthéon, Pinel has robbed the spiritually disturbed person of his metaphysical depths and meaning with the introduction of the medical model. The disturbed person became ill. His disturbance is no more than a medical divergence, a faulty physiology, nothing mysterious about it at all.

8

But the medical model itself is destined to end, according to Van den Berg. A first and important indicator appears in the 1960s. He first signals an architectural gesture in the completion of the Centre Pompidou in Paris, the National Centre of Art and Culture. The Centre looks like a refinery, a monument to technical rhetoric, where the functional has the upper hand as if to underscore that culture is in the service of the useful, and the practical. To see the inner space, the designers have incorporated flexibility and transparency. There is no solemnity in this monument; the unsightly entrance barely has a threshold.

What point is Van den Berg making with this metaphor? We live in an era when we no longer want to see contemporary cultural artefacts and works of art in museums where they become objects of worship. Instead, we would like them to emerge almost coincidentally in a public space, where we tolerate them for a time. We no longer see these artistic projects as mysterious objects; they come into view and disappear again. The gradual ending of the idea of art as something in a museum runs in parallel to the slow disappearance of the medical model of psychiatry. There are fierce attempts

– the anti-psychiatric movements of the 1960s were one such challenge – to portray the person with a spiritual disturbance not as an ill, let alone a disturbed person, but rather as someone who is barely distinguishable from the normal, healthy individual. The development of psychotropic drugs, anti-psychotics especially, makes it possible for many psychiatric patients to never visit a psychiatric clinic. A person with schizophrenia is an out-patient, who may only need regular consultations with a family doctor. This makes it possible for the patient – no longer a disturbed person – to function fairly normally, rarely having to take sick-leave, or at least not more frequently than a patient suffering from heart or lung disease. And so, is it not possible to make a comparison between the schizophrenic patient – a solitary and somewhat orphaned individual who despite everything is still not able to integrate into the society, but who is nonetheless 'liberated' from the medical model – and an abandoned work of art that existed only briefly? Before Pinel, this same schizophrenic was shackled; with Pinel, he or she became a patient with treatment in a hospital. And today, this patient can be found unattended in a park or metro station without becoming a beggar or having to join a group of other marginal characters.

Van den Berg ended his Utrecht lecture with the conviction that we can not return to a period before Pinel, that it is impossible for a schizophrenic to be only a 'patient'. The medical model has had its heyday. Timidly, he makes the observation that "the function of the disturbed person, in the guise as schizophrenic, is to demonstrate metaphysical depth" (1989: 30). He says he knows that people may not understand such an enigmatic remark, but at the same time he claims that it is impossible for him to be more comprehensible. Nonetheless, he takes a stab at it. "The Pantheon shows (metaphorises) the introduction of the medical model, while the Centre Pompidou illustrates the decline of that same model, at least for the psychiatric patient. Now we are waiting for a new building that will demonstrate that justice is being done to the psychiatric patient. Will such a building become a reality? I wish I had an answer to that question" (1989: 30).

9

Van den Berg places phenomenology in the service of anthropology. Using phenomenology to describe how we are directed towards the 'outside' against a horizon of cultural-historical artefacts, he illustrates his theory of Metabletica as the study of altering synchronicities in which medical and psychological phenomena are integrated with other cultural occurrences. It may seem strange at first to look towards architecture to understand strategic changes in medicine, but this can be explained by the fact that culture and its rich historical legacy is our common home.

Is the metabletic method also useful for cultural anthropology beyond European borders? Did Van den Berg consult studies about non-Western cultures? In his *Chronicle of Psychology*, written in 1953 and reprinted with only small changes in 1973, he shows his debt to the cultural anthropologists Ruth Benedict and Margaret Mead, by stating,

> … that psychology can only be a responsible science as long as one continually asks the question about cultural context, even though it is not necessary that the psychologist provides an answer. The culture in which a human being lives and the era in which his social group is formed are both part of the required matrix of every psychological investigation. This is so even when it appears that the study is culturally neutral. Take, for instance, the enquiry into perception; this can only be completely understood if it is first known what a person's relationship is to his world in a particular historical time. Only when it emerges how that person interprets his world is it possible to grasp his way of understanding, which we call 'perception'. (1973: 69; translation MV)

Using similar reasoning, he states in his article *What is psychotherapy?* (1970) that neurotic disturbances are not the same the world over. Patients in different parts of the world, even in different regions, present different symptoms. There are also quantitative disparities. A highly developed society will have a greater number of neuroses than a 'primitive' one; an industrialized state will have greater numbers than an agrarian one. More neuroses exist in a democratic nation than in a dictatorial state, and more in the cities than in the countryside. It is even possible that whole regions will be spared (1970: 23).

Here the author finds the affirmation that we need to look for the origin of neurotic disturbances in the always changing temperament, structure or composition of a land, a people, and an era. In short, we must look in the temporal and geographic context of a specific social group of which the individual is only one small part. (1970: 25) This is central to the phenomenological-metabletic method, which holds that we cannot isolate and disturb a phenomenon, but rather that it remains contextually embedded. After all, a phenomenon is a conglomerate of givens with implications that reach much further than the study of the isolated parts. Van den Berg resists any form of reductionism.

Van den Berg only minimally applied his perspective to non-Western cultures, and when he did so – in the later years of his career when he was a regular guest in South Africa – it was often quite awkward. His vision of Africa was Eurocentric, some even said racist. In his view, Africa would only be able to develop if it followed the Western model, and he was openly sceptical and pessimistic about that possibility (1977: 177). (See also: Zwart 2002: 23).

The kinship between Van den Berg and cultural and medical anthropology can not be found in the cultural relativism that was one of the most obvious characteristics of cultural anthropology at that time. On the other hand, Van den Berg had a sharp eye for the cultural dimension of his own society long before other anthropologists discovered this, and was able to look at illness and the healing arts in his own social group with open phenomenological amazement.

10

Looking 'metableticaly' at his appearance in the 1950s, we can only conclude that not medical anthropology, but rather Van den Berg (and some of his associates – Rümke, Buytendijk, Linschoten) heralded a new era of anthropological thinking about human experiences of body, suffering and healing. It took medical anthropologists 25 additional years to grasp the taken-for-granted cultural meanings of health and illness in their own societies. And it also took medical anthropology more than two decades to pluck the fruits of the phenomenological approach in the study of human beings that flourished in French and German philosophy halfway through the 20th century. That approach was however picked up very early by the psychologist Van den Berg.

In general, anthropologists' blind spot for phenomenology – and medical anthropologists in particular – is puzzling. If there is one discipline where one would expect an eager and rapid embracement of phenomenology it is anthropology with its tradition of prolonged fieldwork and direct encounters with the people under study (Jackson 1989; Becker 2004; Desjarlais & Throop 2011). Knowledge from anthropological fieldwork comes into being through daily experiences and continuous adjusting processes of intersubjectivity. Van der Geest (2012) blames this blind spot on lack of communication and appreciation between anthropology and adjacent disciplines such as philosophy and psychology: academic ethnocentrism. A simple language problem may also have contributed the anthropological myopia. The mainly French and German representatives of phenomenological (philosophical) anthropology (Merleau-Ponty, Marcel, and Heidegger) were not readily accessible to the largely Anglophone international community of cultural and medical anthropology. It is only in the course of the 1980s and 1990s that medical anthropologists have turned explicitly to phenomenological reflections on methodology and analysis in their theoretical (Scheper-Hughes & Lock 1987; Jackson 1989; Csordas 1990; Good 1994; Mattingly 1998) and ethnographic work. Phenomenology-inspired ethnographies appear on sickness, pain and suffering (e.g. Delvecchio Good et al. 1984; Kleinman & Kleinman 1991, Kirmayer 2008; Throop 2010), on healing (e.g. Devisch 1993; Laderman & Roseman 1996) body / embodiment (e.g. Desjarlais 1992) and sensory experience (e.g. Howes 1991). The discovery of the body led to a renewed interest in an early (French) anthropological essay on 'body techniques' (Mauss 1973 [1935]). It is indeed remarkable that Van den Berg's phenomenological reflection on being sick and bodily experience in 1952 was not noticed by anthropologists. An example of this reflection, based on two excerpts from his 'Psychology of the sickbed', has been reprinted in this volume.

Another explanation suggested by Van der Geest for the eclipse of Van den Berg's work was 'geographical'. Halfway through the previous century, anthropologists were overwhelmingly interested in distant cultures and considered most of what was written about their own society as non-anthropology. This was particularly true in the Netherlands, where fieldwork at home was exceptional until approximately the second half of the 1970s. Work by scholars like Van den Berg and his senior colleague and friend, Buytendijk, did not strike the anthropologists as relevant. "If Buytendijk had written his treatise on phenomenological physiology in Borneo, anthropologists

would have embraced him as a colleague. If Van den Berg had written about the sickbed of patients in Congo, the same would have happened" (Van der Geest 2012: 13). That negligence was mutual, as it happened. As we have seen, Van den Berg only became interested in Africa towards the end of his career; it did not enrich his vision. In his publications that are relevant for medical anthropologists, one looks in vain for references to anthropology. Anthropological publications fell outside his enormously wide perspective. And in Buytendijk's (1974 [1965]) magnum opus one finds numerous references to animal studies, but not one to the far-away people who figured so prominently in anthropological monographs.

Ironically, the past 25 years with anthropologists' vivid interest in "… emotion; embodiment and bodiliness; illness and healing; pain and suffering; aging, dying, and death; sensory perception and experience; subjectivity; intersubjectivity and sociality; empathy; morality; religious experience; art, aesthetics, and creativity; narrative and storytelling; time and temporality; and senses of place" (Desjarlais & Throop 2011: 87), did not give Van den Berg the anthropological recognition he deserved. Apparently, his pioneering publications on the phenomenology of body, illness and healing date from too long ago. His death at the age of 98 did not make a ripple in the world of medical anthropology. His name no longer struck a chord. May this brief overview of his vision and work raise some curiosity after all this time.

Notes

Jacques De Visscher was a professor of Philosophy at the 'Hoger Architectuurinstituut Sint-Lucas' in Gent until 2005 and is emeritus professor Philosophy and Literature at Radboud University Nijmegen. He is the author of a phenomenology of everyday life in three volumes (*Over de levensloop*, 1990; *Een te voltooien leven*, 1996 and *Naakt geboren*, 1999). He also published hermeneutical studies about art (*Kunst als spiegel voor de mens*, 1983; *Het verhaal van de kunst*, 1990; *Het symbolische verlangen*, 2002 and *Muzenschemering*, 2003). In 2011, *Het groteske* and *Toewijding* appeared. He wrote several essays about the work of Van den Berg (for example: De Visscher 1995 and 2001). He co-edited a collection of essays about Van den Berg with the psychiatrist Walter Vandereycken: *Metabletische perspectieven* (Vandereycken & De Visscher 1995) and was responsible for the re-publication of some of Van den Berg's books (*De dingen* (1994), *Het gestoorde contact* (1997) and *Koude rillingen over de rug van Charles Darwin* (2009). Email: jeedeevee@skynet.be

Thanks to Sjaak van der Geest for useful comments and to Marianne Vysma who translated and Julia Challinor who edited this text.

1 These two volumes about the changing human body (totalling 600 pages), his most ambitious work, have never been translated in any language.

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