

GIFTS WE GIVE THROUGH EVILS WE TAKE

EMPATHIC EXCHANGE OF EMBODIED EXPERIENCES AS THERAPY

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Abstract

Therapeutic empathy entails understanding a patient's illness and relation to that illness, communicating that understanding and acting on it in a helpful manner. Explanations of its efficacies in improving patient outcomes in the biomedical literature are limited and centre on latent consequences such as facilitating more accurate diagnoses, thus neglecting the role of social processes in healing. In an attempt to provide this insight, this study performs an ethnographic sensory analysis of *xemátiasma*, a Greek healing ritual for the evil eye in which a healer temporarily takes on the evil affecting the patient (thereby partially embodying the patient's symptoms of *mátiasma*), expels it through intense yawning and tearing, and relieves the patient's pain. Much of existing literature on the evil eye in Greece privileges an ocular-centric perspective that focuses on the symbolism of the ritual steps and materials in *xemátiasma* to explain its effectiveness, rather than on the dynamic, lived interaction between patient and healer. By showing how ethnographic accounts of evil-eye infliction invoke visual, acoustic and tactile synaesthetic features, I explore if and how an exchange of embodied experiences occurs in *xemátiasma* and delve into the ritual's social and bodily-felt efficacies. I argue that *xemátiasma* provides evidence for a multisensory form of therapeutic empathy that allows healers to perform acts of care and create new orientations through which patients can experience their illnesses. This relationship between therapeutic empathy and *xemátiasma* provides a platform to contemplate differing claims to efficacy and highlights the importance of social and sensory experiences in healing, including in the biomedical consultation room.

Introduction

This article engages with ethnographic work and critical theories in medical and sensory anthropology to examine therapeutic empathy within the context of a healing ritual for the evil eye in Greece, called *xemátiasma*. Sensory anthropology draws on phenomenology to emphasize the body as a moving entity that elicits sensory experiences and generates potentialities for transformation, making it particularly useful for exploring how *xemátiasma* changes the way the body is oriented in the environment. The central research questions lie in whether and how *xemátiasma* facilitates an exchange in embodied experiences, what the therapeutic efficacies underlying this exchange are, and whether this sensory analysis can challenge and provide insights into the biomedical explanations and outcomes of therapeutic empathy interventions.

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To complicate hypervisual discourse on the evil eye and provide foundations for a discussion of *xemátiasma*'s efficacies, I begin with a sensory analysis of evil-eye infliction, affliction and (re)moval. Second, I explore the multiple efficacies of *xemátiasma* to showcase a synergistic collection of processes that go beyond symbolic descriptions in the existing literature, particularly by exploring the interplay between symbolic, processual, social and bodily-felt ritual efficacies. Finally, I relate *xemátiasma* to empathy in order to consider how ethnographic work can explain the healing mechanisms of therapeutic empathy and oppose it to the understandings of biomedical literature. I conclude with reflections on the implications and recommendations for investigators of the evil eye in Greece and therapeutic empathy, as well as various stakeholders in biomedical health-care systems. The remainder of this introduction provides a background to therapeutic empathy in biomedicine and the evil eye in Greece.

Therapeutic empathy

Empathy, a word coined by Robert Vischer in German as *Einfühlung*, was originally used by the philosopher Theodor Lipps to express how a person can project their feelings into aesthetic objects (Bizzari et al. 2019: 91). To this day, its core meaning lies in the process through which we understand and share in the world from another person's subjective experience, though the ways and extent to which this is possible are widely contested (Hollan and Throop 2011: 2-5). In this article, I engage with a phenomenological approach that highlights the body as central to acts of intersubjective understanding and that frames empathy as a 'dynamic process of embodied, embedded, and actively engaged enquiry' (Hardman and Hutchinson 2020: 4), which some cautiously propose could be complemented by the discovery of mirror neurons (Zahavi 2012: 245-50). By applying Husserl's notions of a *Leib*, or lived body, and of embodiment, which Merleau-Ponty (2002: 112-70) and Csordas (1983: 5-12, 1993: 135-43) expand on, the body's sensory experiences through movement in space can be seen to shape how we empathize with people. Rather than a matter of inference or representation, empathy is one of relations between our immediate embodied experiences and orientations and another's. This is critical in medicine, as cognitive accounts of empathy fail to recognize patients as present, feeling, actively participating beings, and risk perpetuating their treatment as defective machines. Empathy is an intersubjective process involving both the experience of understanding and that of being understood, which differentiates it from projection (Hollan 2008: 482-3). The intersubjectivity of empathy must also be explored with consideration of people's realities, values, discernments and practices.

Therapeutic empathy is both a theory and an intervention that has increasingly been adopted and tested by biomedical institutions through randomized controlled trials (RCTs). It involves not only the interpersonal understanding of empathy, but also caring action. According to Howick (2018b: 233), it entails a three-step process of 1) understanding the patient's pain and illness, 2) communicating that understanding and 3) helpfully acting on that shared understanding. Many studies show that therapeutic empathy improves patient outcomes, including Howick's (2018a) recent systematic review of interventions in which practitioners enhance the expression of empathy through spending more time with patients, attentive bodily gestures and positive expectations (Kaptchuk et al. 2008; Mercer et al. 2012; Little et al. 2015; Elliott et al. 2018). The RCTs in these studies test the effects of empathy on acute and chronic pain conditions, such as those accompanying depression, cancer, osteoarthritis, back pain and diabetes. Interestingly, therapeutic empathy has also been shown to serve as a preventive factor for physician burnout (Thirioux et al. 2016: 8). While the fact that biomedical institutions are acknowledging the significance of the social in therapeutic encounters through this resurging interest in empathic communication in patient-doctor relationships may seem like a positive move, their proposed mechanisms through which therapeutic empathy improves outcomes have shortcomings. These efficacies include increases in practitioners' diagnostic accuracy (as patients are more likely to share concerns and symptoms with empathic clinicians) and a better understanding of patient needs, resulting in personalized, patient-centred treatment, reductions in patient anxiety, and patient empowerment (Mercer and Reynolds 2002: 9; Mercer et al. 2012: 253-4; Howick et al. 2017: 3-4; Howick et al. 2018b: 233). While true, these explanations overlook efficacies that engage the sensory experience of empathetic techniques and the intrinsic value of social processes in enhancing health.

By linking the workings of therapeutic empathy to its ability to lead to accurate diagnoses, prognoses and shared decision-making, its efficacy is attributed to latent functions that reduce the worth and healing powers of emotional, bodily-felt attunement between patients and healers to extrinsic consequences. Apart from these valid but reductionist explanations in the biomedical literature, there is a lack of explanation for how therapeutic empathy is enacted and how it fundamentally mobilizes therapeutic effects in people. I therefore argue that a sensory analysis of *xemátiasma*, a Greek ritual in which a healer temporarily takes the evil from a patient to relieve them of their pain, may prove useful in substantiating the underlying efficacies of therapeutic empathy.

The evil eye in Greece: mátiasma and xemátiasma

The evil eye is an ancient and ever-present phenomenon documented world-wide, a testament to its deep roots in perceptions of well-being and personhood. Here, I will focus on its manifestations in Greece.

Some of the first references to the evil eye in Greece can be traced back to Greek mythology and classical texts that attribute it with substantial potencies that have different sources, from envy and hatred to love and admiration. While Aristotle suggested that vision and the evil eye spread through *pneuma*, a life-sustaining energy and force linked to breath that flows within and between people, Democritus proposed that it is energy effluxes in the whole body that project the evil eye (Elliott 2016: 20, 50-65). The conception of the evil eye as an energy exchange is perpetuated in modern Greece, where many believe that a person's energy inflicts the evil eye and that certain people elicit that energy to greater extents than others. This perspective complements views in sensory anthropology, as it endows active components with vision and speaks to the ability of the body to elicit sensory experiences.

The evil eye in Greece is called *kakó máti*, or 'bad eye', and it results in a bodily illness called *mátiasma* ('eyeing') (Seremetakis 2009: 342). Its symptoms consist of headaches, a lack of energy, dizziness, moodiness, stomach upsets, discomfort and a sense of disconnection, among others. The spreading of the evil eye occurs in everyday social interactions between people; young children and individuals with particular 'distinctiveness' and high social status are considered most susceptible to it (Roussou 2011a: 86). Though *mátiasma* has ties to Christian Orthodoxy (the dominant religion in Greece), being mentioned in the Bible as *vaskanía*, the beliefs and healing techniques of its practice in contemporary Greece also incorporate the influences of eastern spirituality (yoga, feng shui, reiki) and 'New Age' spirituality (energy channelling, incense burning, etc.) (Roussou 2011a: 85; 2011b: 134). Ethnographic studies of *mátiasma* support the idea that people emit energies that tangibly affect others, though a sensory analysis of how this occurs is lacking in the existing literature. Beyond this, the sensory synaesthesia of evil-eye transmission has hardly been explored (apart from some work by Seremetakis (2009)), despite evidence of the interplay between vision, sound and touch in people's accounts of *mátiasma*. This article addresses this gap, as it is important for understanding *xemátiasma*.

Xemátiasma, i.e. 'de-eyeing' or 'taking one's eye out', is a healing ritual for *mátiasma* that is widely performed in Greece today (Seremetakis 2009: 343). While the Church has a similar ritual performed by priests, *xemátiasma* is situated more in the everyday lives of families and communities and is performed by 'lay specialists', most of whom are women

(Roussou 2011a: 86). Most anthropologists have focused on its practice in rural villages, though Seremetakis (2009: 339) and Roussou (2011a: 87-8) point out its persistence in urban settings and between people across large distances, as evidenced by ‘telephonic divination’, or *xemátiasma* carried out over the phone. *Xemátiasma* rituals broadly involve healers taking on the energy of the evil eye that is affecting the patient and expelling it through intense yawning and the tears that shed from their eyes while yawning. At least theoretically, it entails a therapeutic empathy in which a healer partially embodies the patient’s experience of pain, communicates and enacts this exchange through bodily gestures, and relieves the individual’s pain associated with *mátiasma*. By paying attention to the dynamic sensory interaction between patients and healers themselves, rather than just representations of the ritual materials and procedures separated from their social context, I provide an account of a multisensory form of empathy at work in ritual.

Sensory experiences of (*xe*)*mátiasma*

Evil eye transmission in Greece is mediated through energy transformations that are elicited and registered by people, a process in which bodies exchange messages and create bonds of shared substance. To articulate these sensory exchanges, I first outline how the evil eye moves about the world, drawing on ethnographic evidence of sensory synaesthesia that mingles visual, auditory and tactile elements. Then I examine the bodily-felt experience of *mátiasma*, specifically *kommára*, characterized as a sense of disconnection and heaviness that stagnates vitality, in order to set up the foundations for the therapeutic effects *xemátiasma* provides. Finally, I investigate whether *xemátiasma* comprises an exchange of embodied experiences between people.

Synaesthetic exchanges of evil-eye infliction

Major works on this theme (Herzfeld 1981; Veikou 1998) tend to emphasize the evil eye in Greece as a form of ‘ocular aggression’ or ‘visual appropriation’ used as a tool to underpin social classification and the social order (Seremetakis 2009: 341). People who attract the evil eye are especially distinctive enough to escape fading into the background, thereby becoming susceptible to the admiring and envious gazes of others. However, the evil eye is not solely a visual phenomenon; it involves synaesthetic interaction, particularly between sight, sound and tactility. Synaesthesia in this case alludes to Young’s (2005: 61-4) work on the correspondence between greenness and odour for Native Australians in the Western Desert, whose synaesthetic experiences are embodied and socially transmitted, rather than cognitive,

psychologized phenomena. A common expression describing the cause of *mátiasma* is ‘someone eats you with the eyes’ (Seremetakis 2009: 342). Yet, the evil eye is also transmitted through ‘being seen’ or ‘eaten’ by the tongue: people often attribute *mátiasma* to *ghlossofaghiá* (*ghlossa* = tongue and *faghia* = eating) (ibid.). When people talk and gossip about someone, their tongues move in their mouths as if they are eating. Talking about another person with too much of either negativity or admiration is a gesture of oral and ‘acoustic violence’ (ibid.). Those who utter negative things about another have a ‘poison tongue’, or *farmakóghlossa*, and the sounds of these tongues talking spread the evil eye. A voluntary way of casting the evil eye is through a hand movement called *moúntza*, which involves spreading fingers widely and quickly moving the hand with palm facing downward towards another person (Hardie 1923: 160). This can be accompanied by the other hand hitting the dorsal aspect of the hand slanting towards the person, causing a ‘smacking’ sound that adds to its power. When giving a *moúntza*, people often say ‘*ná, pár’ta*’, meaning ‘here, take this’. The existence of *ghlossofaghiá* and *moúntza* points to associations between the gazes of others, the sounds of gossiping, the movements of hands and tongues, and their tangible effects on people as illness. The bodily-felt symptoms of *mátiasma* indicate that ‘someone is thinking about you’ (*kápios se meletáí*), revealing an ability to detect other people considering, chatting about and examining you (ibid.); indeed, in many ways, *mátiasma* is a sense within itself.

How do these sensory modalities intermingle and become transformed into tangible manifestations on people’s bodies separated by long distances, and why can even the looks and sounds of admiration transmit the evil eye? An examination of Roussou’s (2011a, 2011b, 2014) ethnographic accounts of the evil eye in Rethymno, Crete, and Thessaloniki, northern Greece, can partially illuminate this. Many Greek informants consider life to be imbued with a spiritual field of intercommunicating energies; Roussou refers to people as having ‘energetic somata’, *sómata* meaning ‘bodies’ in Greek (2011b: 139-41). As Antonia, a Thessalonikian woman, explains, ‘Mátiasma involves the transmission of energy and thought between people’ (Roussou 2011a: 95). People have certain amounts of energy, of different intensities, moving through porous bodies. When someone comes into contact with and possesses another person’s energy, *mátiasma* occurs. Eva, an evil-eye ritual healer from Thessaloniki, remarks, ‘People’s negative energy often influences me. You feel that there is something negative about a person and, by being in close touch with him, you become negative and moody, or you get a headache’ (Roussou 2011b: 140). This signals that people’s energies have tactile features; they touch people’s bodies and cause bodily-felt symptoms. When people pointing a

moúntza exclaim ‘Take this!’, they imply that they can concentrate negative energy in their hands and push it in the direction of the person they want to inflict. Mina, another informant, explains that you can also inflict *mátiasma* on yourself in the process of spreading it to someone else:

I think that if you cannot manipulate the negative energy you want to send, then don’t do it. Since then, I try to avoid any bad thoughts because I feel I can send negative energy. And it can come back to me, like a boomerang. (ibid.)

Though some informants speak of positive and negative energies, the fact that positive words, looks and thoughts can impose the evil eye suggests that the intensity of energy plays a large role in its ability to precipitate *mátiasma*. The danger of the evil eye may not lie in the energy having an intrinsically negative nature as much as in its capacity to threaten a person’s energetic balance. Ethnographic accounts in a thesis by Souvlakis (2020), focusing on the evil eye in Corfu, provides further evidence for the relevance of balance in evil-eye transmission. A thirty-year old woman named Georgia describes:

When the energy exceeds a certain threshold, or drops below it, then the individual can cause or be inflicted by the evil eye. This means that a negative thought, or just a gaze, can cause damage to someone as the person who emits that energy is highly emotionally charged. (Souvlakis 2020: 113)

The importance of energy balance can also be discerned from evil eye prevention. One is the practice of ‘silencing and low voicing’, explained by Seremetakis (1991: 56; 2009: 343) as a method of self-surveilling pollution resulting from visual and verbal admiration. Seremetakis recalls a story an Athenian doctor shared with her about an old lady from his village:

Every single time she met a gorgeous young woman admired by all, she greeted her with a derogatory word [*ghia sou plakoutsomita mou*; ‘hi, my flat-nosed one’], till she was confronted by the [woman’s] brother. She was doing it to avoid inflicting evil eye on the beautiful woman. (Seremetakis 2009: 343)

To counterbalance the adulatory energy attracted by the woman’s beauty, the older woman greeted her with a derogatory phrase as a protective measure, which ostensibly resembles an insult. Spitting is another popular protective technique; often, when Greek people compliment someone, they spit or imitate spitting on the person by saying ‘*phtoù, phtoù, phtoù*’ to avoid unintentionally inflicting the evil eye (ibid; Lykiardopoulos 1981: 225; Raftopoulos 1983: 30). Again, this superficially rude action is a way of offsetting the excessively positive energy radiated by flattery. One can particularly see people spitting in the presence of babies, who are especially vulnerable; for this reason, young children are adorned

with protective amulets against the evil eye that redirect people's attention, and there is a tradition of keeping babies at home until their baptism, a ritual that helps prevent the evil eye (Hardie 1923: 161; Lykiardopoulos 1981: 226; Raftopoulos 1983: 30, 39).

Though energy is typically perceived as an invisible, intangible force that eludes Western scientific sensory schemas, Greek informants' descriptions of it grant it tactile qualities that can be sensed by the body and experienced through *mátiasma*. It is not clear whether the sights, sounds, movements and touch associated with evil-eye transmission produce this energy, serve as it, or perhaps both. However, there is an intermodal and synaesthetic nature to them, similar to the intermodality of tactile properties of the eyes spreading to other body parts described in Esposito's analysis of *butoh* dance (Esposito 2013: 106-26). That the evil eye has a means of projecting itself through multiple modalities to create a perception of *mátiasma* speaks to the idea that senses 'should not be understood as separate keyboards for the registration of sensation but as organs of the body as a whole, in whose movement, within an environment, the activity of perception consists' (Ingold 2000: 268). The energy exchange of the evil eye is also intertwined with spirituality, as many believe spirits can participate in this exchange. *Pneuma*, a breath-like vital force, is often conceptualized as one's spirit and can also evoke wind; in Greek antiquity, winds circulating a body were linked to 'breaths sustaining life within' (Kuriyama 1999: 229, 236). Parkin (2007: 540-2, 547-8) mentions the cyclical transformation of smell, wind, air, breath and conceptions of spirits described by Bantu-speaking people of the East African coast, where spirits can manifest themselves through smell, wind, or breath, rendering them accessible to the senses. He references Poirier, who explains the interactions between breath, wind and spirit in Kukatja ontology in Australia's Western Desert:

In local representations of the body, when the wind penetrates any one of the human body's openings, it becomes breath; as breath, the wind could not possibly be considered intrusive ... the wind is thus consubstantial with humans: they share the same ancestral essence. (Poirier, 2004: 59)

From this it appears that the energy of the evil eye enters bodies as breath, serving as a shared substance that links people to other people, people to spirits and people to their environments. This potential transubstantiality between breath and energy, in which one substance becomes the other, is made clearer below, in a later section dedicated to *xemátiasma*. The multiple, synaesthetic sensory exchanges of evil eye transmission provide evidence for the materiality of spiritualities and socialities.

Feeling kommára in xemátiasma

When the evil eye disturbs a person's energy, it can result in varying severities of *mátiasma*, an illness characterized by headaches, fatigue, fogginess, and a sense of disconnection, disorientation and isolation. Some people claim that it is the experience of possessing someone else's negative energy; informants in Corfu express the idea that they carry the suffering of another person during *mátiasma* (Souvlakis 2020: 110). One of the most common symptoms is the loss of energy and presence known as *kommára*, semantically related to the Greek word *kóvo*, meaning 'to cut' (Roussou 2011b: 142). In other words, it is an overwhelming feeling of being cut from the rest of the world and of experiencing heaviness, extreme tiredness and numbness. Sofia, a woman from Thessaloniki, describes the experience well:

I feel as if I am not present here. If you ask me to perform a task, I will not be able to understand what you are talking about. It feels like I am one step behind. It is as if I have entered another dimension from which I observe the present one. As if I cannot observe the present. As if I cannot be here. (Roussou 2011b: 141)

Many accounts reflect the sensation of a drop in energy levels, sleeplessness, a weakened spirit, a lack of focus and isolation from both oneself and others. Souvlakis records testimonials from his informants that convey a sense of disembodiment; Stamos, a man in his mid-twenties from Corfu, explains:

I know that I have the evil eye not only because of the symptoms but mostly because there is a strong sense of not belonging anywhere, a sense that my body is not part of me and I am just like [a] ghost, not grounded anywhere. (Souvlakis 2020: 172)

Kommára is a symptom of asynchrony with one's own body, one's social relations and one's sense of time. When someone has *mátiasma*, they lose their *kéfi*—their spirit, joy, motivation, excitement and liveliness. *Mátiasma* resembles the illness of 'spirit loss' of the Yolmo in Tibet that Desjarlais (1996) describes, in which the *bla* or 'spirit' parts from the body and causes a person to feel heavy and lack the energy to socialize, eat or work. Desjarlais writes that the afflicted person 'loses the sense of kinaesthetic attentiveness or presence' (ibid.: 145), which is notably similar to descriptions of *kommára*. As people's symptoms of *mátiasma* lie in core shared experiences of feeling 'cut' from themselves, others and their surroundings, and of possessing someone else's energy, healers must ameliorate this through a ritual that removes this energy, reinvigorates their spirit and re-establishes feelings of embodiment and synchronicity.

Xemátiasma as an exchange of embodied experiences

There are many varieties of *xemátiasma*, depending on influences as wide in scope as the traditions of the region it originates in and as particular as a person's conception of self. Healers are typically women—though men also perform it—who learn it through friends and relatives in their communities (Seremetakis 2009: 341; Roussou 2011b: 138; Souvlakis 2020: 69). When healers recognize symptoms of *mátiasma*, they sit down with the afflicted person in a quiet area and prepare the materials for the ritual. The most popular practice of *xemátiasma* involves the elements of water, olive oil, words (*ta lógia*) and breath. One first takes a cup or bowl, fills it with water and pours three drops of oil into it while mumbling the words, or spell, associated with the ritual. This first step is diagnostic; if the oil dissolves into the water or falls to the bottom, it is clear that this is a case of the evil eye. The healer at this point feels the heaviness of the person with *mátiasma* and begins to yawn:

When someone tells me that he feels strange and he feels *kommára*, that he has the evil eye and all, I feel it. It is like I receive a wave which he casts. I feel an unbelievable heaviness on my forehead, and I want to yawn. I say my prayer. And when I take a big breath I feel I have absorbed his evil eye, I have healed him. (Roussou 2011b: 143)

The intensity of the yawning is a reflection of the strength of the evil eye. Healers continue saying the words and yawning until they absorb the patient's evil-eye energy, and the ritual concludes once the oil stops vanishing in the water. The patient takes three sips of the water, which is then discarded. Finally, the healer asks the person to move out of their position to prevent a relapse; this is also done in everyday life as a preventative measure after one hears bad news or has a bad intuition (Seremetakis 2009: 340). Healers may exchange oil drops with three pieces of hot charcoal or pinches of salt, and some may make the sign of the cross, sprinkle water on to the patient and even stroke the patient's forehead with their thumbs. The significance of the materials, words, numbers and specific steps involved are discussed further in the following chapter.

Healers develop diagnostic knowledge of *mátiasma* based on its manifestations in the patient's body, their own body and the ritual process, though the techniques used to reveal its origins (i.e. the gender of the eye), its presence and its strength are not homogenous. Rituals that also incorporate holy flowers, incense, prayers and other elements have been documented (Hardie 1923: 165-70; Gubbins 1946: 196; Lykiardopoulos 1981: 228-9; Raftopoulos 1983: 34-8; Herzfeld et al. 1986: 110; Souvlakis 2020: 133), illustrating the diversity in the ritual's performance. However, much of this literature overwhelmingly fails to expand on the bodily interaction between healers and patients, leaving readers curious as to how *xemátiasma*

addresses the problems of evil-eye energy imbalance and *kommára*, and how it induces pain alleviation. Roussou (2011a: 95-6; 2011b: 143) describes *xemátiasma* as an exchange of positive energy entering the patient's body from the healer and of negative energy leaving the patient's body, entering the healer's body and escaping. Similarly, Souvlakis's (2020: 132) informants in Corfu state that a healer absorbs the patient's negative energy in order to understand and alleviate the latter's suffering. Taking a closer look at the persistent presence of intense yawning in *xemátiasma* may provide insight into how this is said to occur.

Healers compulsively yawn in the presence of *mátiasma*, causing them to tear up as they 'take on the evil' from the afflicted person; patients then also begin to yawn, allowing the energy associated with *mátiasma* to leave their bodies and enter the healers' (Seremetakis 2009: 342). This practice suggests that yawning and tearing enable the healers to expel the energy they take on from the sufferers. It also supports the transubstantiality between breath and energy, as the energies are absorbed and expelled through the inhalation and exhalation of breath, the shared substance connecting the two bodies. As the healer yawns and momentarily embodies the patient's intense energy and painful experience, the patient embodies the healer's positive energy. Patients ultimately regain a sense of connection with their own bodies and with the healers themselves through this reorientation of the senses towards immersive breathing and towards each other's relationship in the present moment, thus re-establishing a balanced state of energies across them both. Meanwhile, the healer temporarily adopts *mátiasma*-related symptoms; Herzfeld et al. (1986: 110) note during fieldwork in the village of Glendi that healers yawn, weep and even suffer headaches for a while following a healing session. In this way, *xemátiasma* can be considered an exchange of embodied experiences facilitated by yawning and characterized by a radical empathy in which a healer takes on someone else's suffering. However, it is important to note that this does not mean that the healer embodies these experiences of pain identically to the original sufferer; the healer's ability to tap into the embodied painful experience of the patient is only partial, in line with phenomenological approaches to empathy I expand on in the last section. The efficacies of this empathic exchange are multiple, working synergistically to positively transform the patient's condition of *mátiasma*.

Multiple efficacies of *xemátiasma*

In biomedicine, the efficacy of a treatment—its ability to produce a desired effect or a beneficial change—is generally determined through RCTs, which attempt to pinpoint the 'active' effects of treatments in relation to placebo controls. Though the bioefficacy of a

treatment is important, its dominance in clinical research and biomedical health-care renders efficacies rooted in the meanings that patients, practitioners and medications elicit, the processual nature of illness and its alleviation, the contribution of social relationships in everyday life, and the embodied subjectivities that constitute patients' experiences as illegitimate factors of the healing process. *Xemátiasma* relies on a combination of these non-pharmacological-centric factors, thereby contributing to existing evidence of multiple efficacies—the idea that treatment has multiple abilities to provide therapeutic transformation. In this section I first expand on the symbolic and processual efficacies of procedures, materials, side-effects and spells of *xemátiasma* and then elaborate on its social and ritual, bodily-felt efficacies.

Symbols, signs, side-effects and spells

The meanings attached to elements comprising therapeutic environments, including the physicians or patients (appearance, language, attitudes), their interaction, and substances (colours, shapes, amounts, type of treatment), have significant physiological influences on treatment outcomes; this is part of what constitutes the 'meaning response' (Moerman 2002: 14; Moerman and Jonas 2002: 472-4). In *xemátiasma*, one notices the presence and repetition of meaningful numbers that enhance the potency and efficacy of the ritual. The number three is frequently invoked, serving as the amount of times a healer may make the sign of the cross over the water and 'spit' on the patient, the amount of oil or charcoal dropped in the water, the number of pinches of salt thrown into a fire, and the number of sips a patient takes from the water (Hardie 1923: 171; Gubbins 1946: 196; Lykiardopoulos 1981: 228-9; Raftopoulos 1983: 29-39; Roussou 2011b: 143). The number three references the Holy Trinity of Greek Orthodox Christianity, tapping into the perceived power of the sacred. Many of these rituals also include the number forty (*saránda*), which has multiple references in the Bible as the length of liminal periods that are precursors to positive changes and new phases, such as the number of days between Jesus' resurrection and ascent. There is also a tradition in which mothers who have recently given birth remain indoors for forty days before the baby's baptism, which marks a return to normality (Hardie 1923: 161; Herzfeld et al. 1986: 110; Seremetakis 2009: 343). Healers may repeat their spells forty times, count to forty, massage patients' foreheads with salt forty times, or sprinkle water on their patient eight times with five fingers to make up the number forty. Healers, having completed a *xemátiasma*, take forty steps to alleviate the symptoms they have taken on (Herzfeld et al. 1986: 110). The number has such ritual significance that *xemátiasma* is also referred to as *sarándisma* (ibid.;

Seremetakis 2009: 343). The use of meaningful numbers in this ritual is one example of its symbolic efficacies, which centre on the ability of symbols to materialize meanings, as well as emotional, spiritual and other affective forces, in treatment (Wahlberg 2008: 82).

As discussed earlier, various signs throughout the process of *xemátiasma* (dis)confirm the presence and intensity of the evil eye. This shows an intimate interplay between the symbolic and processual efficacies of *xemátiasma*; processual efficacy refers to how the passage of time and the series of outcomes throughout a therapy determine whether a treatment works. If the oil used in *xemátiasma* creates a separate layer from the water, as expected, then there is no evil eye. If the oil disperses in smaller amounts, then the case is not a strong one. However, when the ‘water drinks the oil’ (the oil is dissolved) and the healer yawns, this signals its intense presence (Hardie 1923: 164; Raftopoulos 1983: 29; Seremetakis 2009: 343; Roussou 2011b: 143; Souvlakis 2020: 133). A healer continues the *xemátiasma* until the oil stops dispersing or dissolving, making this sign integral to determining whether the therapeutic process is working. The water and oil utilized in *xemátiasma* have significance in their own right as well. As one informant states, water is critical in *xemátiasma* ‘because we cannot live without it, it is a natural element of nature and of the human organism, and important for baptism’ (Roussou 2011b: 148). The water must be brought into the ritual space in silence to ensure it is ‘unspoken’ (*amílito*); speaking pollutes the ‘purifying ability of the water’ and compromises the ritual’s effectiveness (Gubbins 1946: 196; Lykiardopoulos 1981: 228; Souvlakis 2020: 132). Olive oil is a sacred gift in Greece’s history and mythology and is incorporated in many church rituals. The oil for the ritual often comes from the oil lamp (*kandili*) that is lit daily in the iconostasis, a family altar of holy icons and a place for reflection in many Greek homes (Roussou 2011b: 143; Souvlakis 2020: 132-3). The meanings of side-effects provide another example of symbolic efficacy in relation to processual efficacy; Etkin explains, in the context of Hausa interpretations of therapeutic outcomes in Nigeria, that what is called a side-effect in biomedicine is interpreted as an indicator that a therapy is ‘on course’ in other medical paradigms (Etkin 1992: 102). In *xemátiasma*, a patient who sneezes, hiccups or feels itchy during the ritual tells the healer that the ritual is working (Raftopoulos 1983: 35-6; Seremetakis 2009: 343, 346). Seremetakis (*ibid.*: 342) explains that body parts exchange messages with each other and with other bodies, these ‘involuntary gestures’ confirming the efficacy of the *xemátiasma*.

The words a healer speaks throughout *xemátiasma* consist of religious prayers and ‘narrative charms’ with rural imagery, such as those documented by Hardie (1923: 166-7) in northern Greece. She also records words associated with the cleansing nature of *xemátiasma*,

including washing away evil eyes, curses and days. The symbolism of washing away the evil is enacted by disposing of the used water at the end of the ritual. When healers drop hot coals into water or throw salt into a fire, they demand that the evil eye burst along with the sounds of live coal sizzling and salt sputtering (ibid.: 169). Other religious spells tap into the divine powers of the sacred, calling to Christ and the saints to conquer ills and facilitate the return of evils to their original source. The manner through which healers transmit knowledge of these ritual words to other people has important consequences for the words' efficacy, which is why I avoid sharing them in their entirety. One tradition claims that a woman who wants to reveal the words to another woman must first pass them through a male mediator and *vice versa* to prevent their effectiveness being lost (Hardie 1923: 165; Herzfeld et al. 1986: 109-10; Roussou 2011b: 137; Souvlakis 2020: 126). Herzfeld explains that this restrictive transmission prevents the dilution of spells and loads the responsibility on to the healers: 'as heirs to formulae that must be transmitted by the sexual zigzag rule, they are themselves significant elements within the expressive complex of curing that they direct' (Herzfeld et al. 1986: 110). The words' efficacy may also cease if they are said out loud by one person using them to another who wants to use them in the same lifetime; people avoid this by sharing them through writing (Hardie 1923: 165). For this reason, healers whisper or murmur the spells during *xemátiasma* so they are not stolen. Seremetakis (2009: 343) shares how her elderly relative once complained about a popular Greek television programme broadcasting people's testaments of *xemátiasma*'s effectiveness, where some even shared their spells; 'They speak truth, but who on earth heard of giving your spell out in public! What do they think it is, an aspirin? What value do these spells have now?' This comparison with an aspirin reveals the symbolic meanings attached to *xemátiasma* spells—words shared intimately as gifts. As Seremetakis explains, aspirin is 'cheap' in comparison to *xemátiasma*. It also lacks symbolic meaning and does not 'speak'; rather, it is a 'utility item' that anyone willing to pay its small cost can buy (ibid.: 344). *Xemátiasma*, meanwhile, is a priceless exchange between giver and receiver, in which healers are willing to share their words, time and energy, and both witness and take on another's pain. People respond in medically significant ways to the values, symbols and social gestures in healing processes, emphasizing the extent to which healers manage meaning in and alongside medicine (Sullivan 1993: 230).

Caregiving and synchronicity via somatic witnessing

Xemátiasma, as often performed by close friends and relatives, serves to reaffirm relationships and allows loved ones to perform acts of care, especially in communities

separated across long distances as a result of urbanization and globalization. The popularity of telephonic divination, in which healers perform *xemátiasma* over the phone, attests to this. As cities do not share the proxemic interconnectedness of rural villages, telephonic *xemátiasma* provides a means of overcoming social isolation and fragmentation (Seremetakis 2009: 339-40; Roussou 2011a: 95). A phone closely attached to the ear and almost touching the mouths of both the patient and healer creates a sense of continuity and privacy, one that is necessary during *xemátiasma*. It provides an opportunity for people living far apart to remain core contributors to the health and alleviation of suffering of their loved ones and practice ‘the ethic of helping’ (Seremetakis 2009: 340). After healers complete a telephonic *xemátiasma*, they hang up and expect the patients to call back to confirm that their *mátiasma* has disappeared. This is part of an ‘antiphonic relation’, referring to a dynamic of reciprocity in acts of giving and taking (ibid.). Seremetakis’s (1991) fieldwork on the mourning songs called *miroloi* in Greece’s Mani region relays the significance of antiphony in ritual transformation. After someone’s death, female mourners (*moiroloyístres*) organize mourning rituals (*kláma*) in which the woman closest to the deceased (*koriféa*) and the chorus of *moiroloyístres* practice an ‘antiphonic’ dynamic as they continuously ‘take the lament from each other’ (Seremetakis 1991: 99-100). Without kin reciprocating and validating each other’s pain, there is a poverty of witness that manifests itself in a silent and ‘bad death’ (ibid.: 76). During *xemátiasma*, the healer not only witnesses the patient’s pain, but also attempts to embody it to alleviate the latter’s suffering. By taking the pain of another in return for bodily and verbal confirmation, the healer and patient participate in an antiphonic relation. Healers are offended when a patient compromises this exchange by failing to call back after a telephonic *xemátiasma*, as this leaves the ritual incomplete (Seremetakis 2009: 340). Just as the pain of death must be dealt with in the context of antiphonic relations to be valid and true (Seremetakis 1991: 120), so must *mátiasma* and its alleviation through *xemátiasma*. This is the social efficacy of *xemátiasma*—the ability to affect betterment through ‘the relations between those enacting illness and treatment’ (Whyte et al. 2002: 23). Whyte et al. develop this concept through Hardon’s study of self-care techniques in Metro Manila’s neighbourhoods, detailing mothers’ evaluations of medical efficacies in allowing them to perform duties as caregivers and allay relationship distress (ibid.: 25-6). The witnessing and reciprocal exchange of *xemátiasma* is an act of care that reinforces relationships between healers and patients and ensures the effectiveness of the ritual. Lock’s study of moxibustion in Japan and commentary on how sick time provides opportunities to fulfil *amaeru*, ‘a desire to presume upon another’s love’, and communicate feelings in nurturing actions also portrays a

social efficacy grounded in care-giving performance (Lock 1978: 163-4). Witnessing in *xemátiasma* is expressed and experienced somatically, making tangible the social relationship between healer and sufferer.

The ‘somatic witnessing’ in *xemátiasma* consists of bodies talking to each other as they yawn, sneeze, hiccup and confirm the efficacy of the ritual (Seremetakis 2009: 340-2). The yawning of a healer followed by that of the patient facilitates an exchange of embodied experiences in which the patient regains feelings of attunement with themselves and other people and serves as proof of *xemátiasma*’s efficacy. I argue that this bodily exchange is a form of ‘generating synchronicity’ in which a patient and healer are immersed in the same event, thereby materializing their relationship and creating predispositions for positive transformation (Hsu 2017: 92-5). Hsu describes this phenomenon in acupuncture when a doctor works on needles inserted in certain loci on a patient’s body until there is an instance of tension and concentration between them; this marked moment of presence is maintained until the patient calls out, ‘Dele, dele [alright, alright]—I got it [the *qi*]’ (Hsu 2005: 78). This shared, synchronic heightened alertness between healer and patient opens up and predisposes the patient’s body to positive change and makes the social relationship between them ‘physically real’ (Hsu 2008: 439). Furthermore, this elicitation of bodily-felt *de qi* is a crucial indicator of acupuncture’s efficacy (Hsu 2011: 167). When the patient and healer are both immersed in intense yawning during *xemátiasma*, they orient themselves to their breathing and each other. This synchronization necessitates an engagement with the present moment, calling for the afflicted person to pay attention to the exchange of breath between them and the healer. Reclaiming a sense of presence is a major goal of *xemátiasma*, given that the illness of *mátiasma* is characterized by a lack of it, providing support for the therapeutic qualities of generating synchronicity. This comparison is particularly interesting given the similarities between the *qi* flowing through bodily channels that acupuncture facilitates and the pneumatic exchange of energy implicated in *xemátiasma*, with both *qi* and *pneuma* described as vital energy sources akin to breath (and associated with wind) that sustain the body alongside blood (Kuriyama 1995: 17, 43-5; 1999: 199, 236). Similar to how *de qi* constitutes the opening phase of a ritual (Hsu 2017: 94), referring to the ‘stage of separation’ of van Gennep (1909) or the ‘predisposition’ stage of Csordas (1983: 27-30), that separates patients from their habituated states and awakens them, yawning in *xemátiasma* (ironically) serves as an energy-enhancing body technique that quite literally opens patients up and reorients their senses towards the immediate bodily reciprocity with the healers. The somatic witnessing of *xemátiasma* generates a synchronicity between patient and healer, making the

antiphonic relationship between them physically real, even when they are miles apart. Yawning is a ritually induced, bodily-felt efficacy in *xemátiasma* that reinforces its social efficacies, providing an example of how the senses mediate social meaning and social relations. The accessible nature of *xemátiasma*, as one can call up a relative or go next door to a family member to receive it at no cost, also provides insight into how its social efficacies reinforce the economic efficacies of its affordability and sustainability. In reality, it is impossible to strictly categorize these efficacies, as they often overlap and serve manifold functions. For example, yawning, sneezing, hiccupping and itching reside at the intersection of symbolic, processual and bodily-felt efficacies. None of these mechanisms work alone; instead, they cooperatively interact in multiple directions with differing intensities depending on the context in order to induce therapeutic effects.

***Xemátiasma* ↔ therapeutic empathy**

Coming to an end of this analysis of the sensory experiences of evil-eye infliction, affliction and (re)moval, and the multiple efficacies of *xemátiasma*, I now incorporate its findings into the larger conversation about empathy, more specifically therapeutic empathy. I first clarify how the exchange of embodied experiences that occurs in *xemátiasma* relates to phenomenological approaches to empathy and establish to what extent *xemátiasma* entails therapeutic empathy. I then explore how the analysis of *xemátiasma* can contribute to the workings and efficacies of therapeutic empathy beyond its barely discussed (and, if discussed, often limited) explanations and finally consider the implications for criteria of legitimacy and truth in medicine.

Xemátiasma in relation to (therapeutic) empathy

Ethnographic accounts of *xemátiasma* indicate that a healer and a patient undergo an exchange of embodied experiences, in which the healer takes on (and subsequently expels) the painful symptoms of an afflicted person's *mátiasma* through a variety of bodily techniques to alleviate the burden of the latter's suffering. I would argue that this engages empathic processes, as the healer attempts to share in the patient's painful subjective experience. As Husserl points out, due to the asymmetry between any two people, there is an alterity in their experiences of empathy; one person cannot have genuine first-hand access to another person's lived experience in that person's body using their own body (Husserl and Cairns 1982: 108-120). The exchange that occurs in *xemátiasma* is not an exact 'swap' of whole subjectivities between healer and patient, but rather a bodily dialogue engaging

multiple efficacies that then leads to an exchange of experiences that are embodied differently in both of them. The patient's original experience of pain is not the same as the healer's eventual experience of pain in *xemátiasma*; the healer takes on the energy that induces another *manifestation* of the patient's original embodied experience of pain. Though healers take on the energy causing the patient to feel ill, their symptoms of temporary *mátiasma* (if they do not manage to fully expel them in the process of *xemátiasma*) often manifest themselves in different ways. The patients may have come down with a headache and fatigue, whereas the healers may feel instead an upset stomach for a while after 'taking the evil' upon themselves. The connections and synchronicities formed through the somatic witnessing between healer and patient in *xemátiasma* facilitate an embodied intersubjectivity, as the healer attempts to understand and experience bodily the kind of pain the patient is similarly feeling. This phenomenological feature of 'opacity' in empathic encounters (Bizzari et al. 2019: 92) extends to *xemátiasma*, though it does push its boundaries.

To recall, therapeutic empathy as defined by Howick et al. (2018b: 233) and inspired by Mercer and Reynolds (2002: 10) specifically includes 1) understanding what an illness means to patients, 2) communicating that understanding and 3) acting on that understanding in a helpful and therapeutic way. In *xemátiasma*, a healer 1) not only understands what *mátiasma* means to the patient but also physically embodies similar (though not exact) symptoms of it, 2) communicates this embodied understanding through bodily gestures such as yawning and tearing, and 3) in the process alleviates the patient's pain. However, there are a few key differences. Though the definition of therapeutic empathy outlines three seemingly separate 'steps' that may initially be interpreted as linear, *xemátiasma* seems to accomplish all three simultaneously. The healer's understanding of the illness, communication of this understanding, and helpful and healing contribution can all occur at once, all through the techniques and expressions of the healer's body as it takes up the evil-eye energies imposing *mátiasma* on the patient. I suggest that what is imagined in the case of therapeutic empathy as described in the biomedical literature is that a doctor understands what an illness means to a patient by examining the latter's body and following descriptions of the patient's experience with it, rather than taking on that experience of pain themselves, as is done in *xemátiasma*. A healer still does this prior to enacting the ritual of *xemátiasma* itself, though this understanding takes on new, explicitly embodied dimensions during the ritual. Furthermore, the communication of the shared embodied understanding that occurs in *xemátiasma* through bodily gestures of yawning and tearing up is unlikely to be the same as the kind envisioned in Howick's interpretation; in biomedical clinical settings, the communication would come in

the form of verbal validation, a touch of the shoulder, eye contact, nodding, etc. However, once again, this kind of communication also occurs between healer and patient just prior to the start of the *xemátiasma*; it is just further reinforced during the somatic witnessing that occurs throughout the ritual. In these ways, the entire process of *xemátiasma*, from the moment a patient expresses painful symptoms to the completion of the ritual, does not just *entail* therapeutic empathy, but reveals to be a deeper, expanded version of it. There are limitations to this relation, given that the construction of the definition of therapeutic empathy did not have illnesses like *mátiasma* and rituals like *xemátiasma* in mind. The empathetic interventions discussed in the meta-analyses of therapeutic empathy consist of verbal and non-verbal validations of pain, longer consultations, positive expectation-inducing suggestions of treatment effects, two-way discussions allowing the patient to ask questions and the clinician to provide explanations, verbal emphasis on patient comfort and well-being, clarifications of patients' understandings of the causes or meanings of their condition, warmth, smiling, active listening, eye contact, a slight leaning towards the patient, hand gestures, etc. (Mercer and Reynolds 2002; Mercer et al. 2012; Elliott et al. 2018; Howick et al. 2018a). These are by no means equivalent to the techniques of *xemátiasma*, even though many of these qualities are intrinsic to its ritual process, including verbal and non-verbal validations of pain, longer times spent between patient and healer, positive expectations (when healers tell their patients that they will take the evil inflicting *mátiasma* away from them), and attentive body language. As expressed by Howick, empathy interventions are difficult to standardize, as there is no single form of empathy (Howick et al. 2018a: s2-3). Though *xemátiasma* and the empathetic interventions of biomedical clinical settings are not to be conflated as equal (especially given that not even the interventions comprising the latter category can be), they certainly share similar qualities and aspirations defining the framework of therapeutic empathy. I contend that *xemátiasma* involves a radicalization of the processes outlined in the definition of therapeutic empathy. *Xemátiasma* suggests the existence of a therapeutic empathy that goes beyond intellection and affect and foregrounds its bodily and multisensory engagements.

Reframing the efficacies of therapeutic empathy

If one treats *xemátiasma* as a radical therapeutic empathy, then to what extent can the efficacies of *xemátiasma* help reframe the efficacies of therapeutic empathy as discussed in the biomedical literature? The latter claims that the efficacies of therapeutic empathy lie in more accurate diagnosis and prognosis, enhanced patient satisfaction, shared decision-

making, anxiety alleviation, patient-centred treatment and ‘patient enablement and compliance’ (Mercer et al. 2012: 254). These are significant and valuable contributions of therapeutic empathy, but they do not grasp the crux of its efficacies. These are all *extrinsic outcomes related to* activities of therapeutic empathy; they are not intrinsic to the therapeutic effects of empathy itself. Keeping in mind the intertwined social and embodied efficacies of *xemátiasma*, one can recognize in these explanations the lack of therapeutic powers attributed to the social interactions that are intrinsic to therapeutic empathy.

The foregoing analysis of *xemátiasma* has revealed that part of its efficacy resides in its ability to demonstrate care and generate synchronicity through antiphonic relations of somatic witnessing. This reorients the senses of both patient and healer to the present moment and to each other, enhances vitality and attunement, makes their relationship feel physically real, and contributes to the opening phase of transformation that predisposes the patient to positive change. Though perhaps to a lesser extent, the empathic interventions described in the biomedical literature also establish a kind of synchronicity through an antiphonic relation between patient and healer. The above interventions that emphasize the importance of time and bodily (including verbal) gestures to enhance the ability of both healer and patient to fully attend to each other are acts of simultaneous immersion; do they not also generate synchronicity through their modes of witnessing? Is the performance of care and empathy in these interventions not a source of its efficacy? Given that a biomedical clinical consultation is certainly not devoid of ritual, therapeutic empathy could contribute to the opening phase of the transformation discussed in ritual practice. Therefore, these practices of therapeutic empathy, which predispose and open up the patient to the potentialities of the positive effects of subsequent treatment, serve an integral role in affecting transformation—they are acts of healing within themselves. Therapeutic empathy is efficacious not just in its capacity to lead to better diagnoses or patient-centred decisions, but in its capacity to create new orientations through which patients understand and experience their illness through the heightened attention and alignment between healers and patients it affords. Allowing patients and healers the time to attend to and ‘witness’ one another and granting the opportunity for physicians to show that they care about the patient are powerful components of the healing process.

Contestations for truth in medicine

This comparison between *xemátiasma* and therapeutic empathy reveals problems in biomedicine’s practices of delineating truths in claims of efficacy. The RCT pinpoints the specified activity of a treatment as opposed to the ‘unspecified’ activities of a placebo

(Sullivan 1993: 221). The term ‘placebo’ has been widely used to describe the ‘unspecified effects’ of a treatment, including contextual factors of care, such as branding and labelling medication, method of treatment, and verbal and non-verbal cues imparted by practitioners. As placebo effects are placed in contrast to the ‘specific activity’ that determines a treatment’s ‘true’ efficacy, placebo effects have been rendered illegitimate for biomedical standards. The ambiguous nature of the definition of a placebo has unsurprisingly helped perpetuate the misguided idea that healing methods that fail to fit the standards of biomedical practices are ineffective and even fraudulent. This risks marginalizing non-biomedically focused healing practices that incorporate the significance of sensory experiences and meaning-creation in the healing process. This is precisely why institutions like the National Health Service and National Institute of Health formerly label them as ‘alternative’ or ‘complementary’ in the first place (National Health Service, 2018; National Institute of Health, 2018). Therapeutic empathy seems to bypass these troubles, despite its emphasis on what RCTs would designate the ‘unspecified activities’ of patient–doctor interactions. From a biomedical standpoint, a ritual such as *xemátiasma* would be reduced to the category of a placebo. However, the efficacy of therapeutic empathy interventions for which the existing literature provides only limited explanations have been accepted as part of that category of ‘specified effects’ that more traditional healing practices are rarely attributed. Why is a ritual like *xemátiasma* so susceptible to trivialization, when therapeutic empathy is not?

This inclines me to consider the very political entanglements of the adoption of placebo controls. Delving into the history of the RCT reveals that its invention stemmed not only from a desire for rigorous treatment evaluation, but also a struggle for the power that comes from funding and academic support. In other words, it was a tool for building a discipline (Kaptchuk 1998: 393). Biomedicine did not innocently choose not to elaborate on the so-called non-specific effects that make up the context of care; their dismissal was a means of asserting superiority over treatment practices that value them (Kleinman 1997: 33). Powerful stakeholders in biomedicine—including insurance companies and pharmaceutical representatives—maintain biomedicine’s status as the ‘official supplier of health services to the populace’, partly by examining the claims of ‘alternative’ medicine (Waldram 2000: 617). Unlike *xemátiasma*, and despite its inherently empathetic processes, the concept of therapeutic empathy was devised in consideration of a western clinical form of consultation and is just subtle and ‘toned-down’ enough to not challenge the interests of the biomedical stakeholders just mentioned. Therapeutic empathy interventions, which encourage physicians to give time to patients, validate their pain, open up a reciprocal dialogue, attentively engage

them, and express warmth and positivity, demand what should be expected to be practised during consultations. However, short consultation times, huge caseloads, long working hours and meticulous documentation in electronic medical records (leading to less attention being paid to patients), among other factors, precludes physicians from doing so (Shanafelt et al. 2016; Patel et al. 2018; West et al. 2018). This makes evident the dangers of constructing a health-care system without consideration of social and sensory efficacies in healing, ultimately burdening physicians and doing a disservice to patients in the process. The fact that therapeutic empathy interventions are accepted as efficacious, while rituals like *xemátiasma* that intrinsically enact forms of empathetic care are side-lined as placebos, remains open to question. It seems that stakeholders in biomedical institutions are only willing to accept efficacies they can maintain dominance over, despite the evident reality that they have much to learn from the ritual practices they dismiss.

Conclusions and recommendations

By means of a sensory analysis of *xemátiasma* and its relation to therapeutic empathy, this article has contributed to efforts to articulate the value of sensory experiences of ritual healing, further the claim for multiple efficacies, advocate the use of ethnographic evidence in elaborating medical concepts, and challenge biomedicine's neglect of the social in precipitating therapeutic outcomes. I started by describing the background to the advances and shortcomings of therapeutic empathy in biomedical practice and argued that a closer look at multisensory processes of empathy at work through the ritual of *xemátiasma* could provide an explanation where biomedical literature could not. To do this, I first explored the sensory experiences of evil-eye infliction, affliction and (re)moval, arguing: 1) that its transmission, perception and practice involve a synaesthetic, transubstantial energy exchange between people, challenging its depiction as an ocular-centric phenomenon; 2) that *mátiasma* is experienced as *kommára*, which is characterized by disconnectedness, disorientation, heaviness and asynchrony with one's own body, other bodies and time; and 3) that *xemátiasma* entails an exchange of embodied experiences in which healers take the pain-inducing energies of their patients on to themselves through a series of bodily techniques, most importantly yawning. Second, I analysed the multiple efficacies of *xemátiasma*, elaborating the interplay between 1) symbolic and processual efficacies of numbers, signs, materials, gestures, side-effects and words (and their cautious dissemination), and 2) social and bodily-felt efficacies in materializing long-distance socialities, enabling loved ones to perform sustainable acts of care, and engendering predispositions to new orientations through

generating synchronicity facilitated by somatic witnessing and antiphonic relations between healer and patient. Finally, I returned to the topic of empathy 1) to establish *xemátiasma* as a radical multisensory manifestation of therapeutic empathy; 2) to suggest that the efficacies of therapeutic empathy do not just centre on outcomes that are external to social processes, but also on their capacity to reorient the patient to new understandings and experiences of their illnesses and predispose them to positive change through processes of performing care and generating synchronicity; and 3) to argue that biomedicine's adoption of therapeutic empathy and its simultaneous marginalization of it in ritual practice that challenges its narrow standards of efficacy is intentionally rooted in a desire to maintain its powerful status.

To improve understanding of the techniques of accomplishing the radically empathic exchange of embodied experiences that occurs in *xemátiasma* and the ways it affects therapeutic transformation, more ethnographic research is needed focusing on sensory experiences and interactions between patient and healer, rather than solely on the symbolic meanings of the ritual. Given the similarities in the associations of breath, wind, energy flow and vitality between Chinese and Greek conceptions of health, future research should investigate these patient–healer interactions in rituals from both regions, such as acupuncture and *xemátiasma*, that attempt to manipulate this energy for the sake of healing.

Furthermore, researchers of therapeutic empathy should explore ethnographic accounts of empathy in healing practices both inside and outside biomedical frameworks to learn more about its intrinsic social and bodily-felt efficacies, the existence of multiple types and multisensory enactments of therapeutic empathy, and the allowances and boundaries in the extent to which we can understand and feel another's pain. Due to the increasing need to attend somatically to patients in health-care and the concurrent increasing constraints on physicians in being able to do so, and despite efforts in the direction of 'patient-centred care', biomedical health-care requires a structural, educational and cultural shift to re-establish the practice of medicine as a meaningful ritual interaction. One step towards accomplishing this is to ensure that pre-medical and medical education encourages critical analysis of claims for what treatment deserves to be called efficacious and clarifies that the 'contextual factors of care' that have fallen into what constitute the placebo effect should not be rendered less important than active drug ingredients, as this dismisses crucial healing efficacies of sensory and social experiences in patient–doctor interactions. These efficacies should be taught by experts like medical anthropologists in medical schools, so that future physicians have a stake in countering the mode of technological fixation, desensitization and detachment that accompanies the 'clinical gaze'.

Health-care administrators, policy-makers and researchers who influence and structure medical learning environments and the delivery of care also need to incorporate this knowledge into their training to *allow* physicians to properly attend to and give time to their patients. This calls for longer consultations, the incorporation of specialists to assist in electronic health-care record documentation, scheduling that incorporates follow-up continuity and shorter shifts, among other changes. There also needs to be more research on sensory experiences in ritual healing in order to build educational curriculums that foster respect for and acknowledgement of the mingling of the social and biological in medicine early on, as well as structural adjustments in the everyday practice of care delivery for physicians themselves to attentively understand, respond to and relieve a patient's pain. *Xemátiasma* makes it clear that the virtues of therapeutic empathy lie at least partly in facilitating the performance of attentive care, establishing multisensory exchanges of healing gifts and painful evils, and creating positive predispositions and reorientations in talking bodies that long to be listened to, thus helping reintroduce core aspects of ritual care into biomedical clinical consultations.

References

- Bizzari, V. et al. 2019. Defining therapeutic empathy: the philosopher's view, *Journal of the Royal Society of Medicine*, 112(3): 91–95, DOI: 10.1177/0141076819831869.
- Csordas, T.J. 1983. The rhetoric of transformation in ritual healing, *Culture, Medicine and Psychiatry*, 7(4): 333–375, DOI: 10.1007/BF00052238.
- Csordas, T.J. 1993. Somatic modes of attention, *Cultural Anthropology*, 8(2): 135-56, DOI: 10.1525/can.1993.8.2.02a00010.
- Desjarlais, R.R. 1996. Presence. In C. Laderman, and M. Roseman (eds.), *The performance of healing*. London: Routledge, 143–164, DOI: 10.4324/9781315538860-6.
- Elliott, J.H. 2016. *Beware the evil eye, Volume 2, Greece and Rome: the evil eye in the Bible and the ancient world*. Eugene, Oregon: Cascade Books, DOI: 10.2307/j.ctv1131hck.
- Elliott, R. et al. 2018. Therapist empathy and client outcome: an updated meta-analysis, *Psychotherapy*, 55(4): 399–410, DOI: 10.1037/pst0000175.
- Esposito, P. 2013. *Butoh dance in the UK: an ethnographic performance investigation*. PhD thesis, Oxford Brookes University.
- Etkin, N.L. 1992. 'Side effects': cultural constructions and reinterpretations of western pharmaceuticals, *Medical Anthropology Quarterly*, 6(2): 99–113, DOI: 10.1525/maq.1992.6.2.02a00010.
- Gennep, A. van [1909] 1960. *The rites of passage*. London: Routledge.

- Gubbins, J.K. 1946. Some observations on the evil eye in modern Greece, *Folklore*, 57(4): 195–198, DOI: 10.1080/0015587X.1946.9717836.
- Hardie, M. M. 1923. The evil eye in some Greek villages of the upper Haliakmon Valley in West Macedonia, *Journal of the Royal Anthropological Institute of Great Britain and Ireland*, 53: 160–172, DOI: 10.2307/2843757.
- Hardman, D., and P. Hutchinson 2020. Cultivating the dispositions to connect: an exploration of therapeutic empathy, *Medical Humanities*, Epub ahead of print, 0: 1-7, DOI: 10.1136/medhum-2020-011846.
- Herzfeld, M. 1981. Meaning and morality: a semiotic approach to evil eye accusations in a Greek village, *American Ethnologist*, 8(3): 560–574, DOI: 10.1525/ae.1981.8.3.02a00090.
- Herzfeld, M. et al. 1986. Closure as cure: tropes in the exploration of bodily and social disorder [with comments and replies], *Current Anthropology*, 27(2): 107–120, DOI: 10.2307/2742968.
- Hollan, D. 2008. Being there: on the imaginative aspects of understanding others and being understood, *Ethos*, 36(4): 475–489, DOI: 10.1111/j.1548-1352.2008.00028.x.
- Hollan, D.W. and Throop, C. J. 2011. The anthropology of empathy: introduction. In D.W. Hollan and C.J Throop (eds.) *The anthropology of empathy: experiencing the lives of others in Pacific societies*. New York; Oxford: Berghahn Books, 1-21.
- Howick, J. et al. 2017. Effects of changing practitioner empathy and patient expectations in healthcare consultations, *Cochrane Database of Systematic Reviews*, 2017(11): 1-17, DOI: 10.1002/14651858.CD011934.pub2.
- Howick, J. et al. 2018a. Effects of empathic and positive communication in healthcare consultations: a systematic review and meta-analysis, *Journal of the Royal Society of Medicine*, 111(7): 240–252, s1-s56, DOI: 10.1177/0141076818769477.
- Howick, J., V. Bizzari and H. Dambha-Miller 2018b. Therapeutic empathy: what it is and what it isn't, *Journal of the Royal Society of Medicine*: 111(7): 233–236, DOI: 10.1177/0141076818781403.
- Hsu, E. 2005. Acute pain infliction as therapy, *Etnofoor*, 18(1): 78–96, DOI: 10.2307/25758087, DOI: 10.2307/25758087.
- Hsu, E. 2008. The senses and the social: an introduction, *Ethnos*, 73(4): 433–443, DOI: 10.1080/00141840802563907.
- Hsu, E. 2011. Treatment evaluation: an anthropologist's approach. In V. Scheidand H. MacPherson (eds.), *Integrating East Asian medicine into contemporary healthcare*, Edinburgh and New York: Churchill Livingstone Elsevier, 157-172.
- Hsu, E. 2017. Durkheim's effervescence and its Maussian afterlife in medical anthropology, *Durkheimian Studies*, 23(1): 76–105, DOI: 10.3167/ds.2017.230106
- Husserl, E., and D. Cairns 1982. *Cartesian meditations: an introduction to phenomenology*. 7th edition. The Hauge; Boston; London: Martinus Nijhoff Publishers.

- Ingold, T. 2000. *The Perception of the environment: essays on livelihood, dwelling and skill*. London: Routledge.
- Kaptchuk, T. J. 1998. Intentional ignorance: a history of blind assessment and placebo controls in medicine, *Bulletin of the History of Medicine*, 72(3): 389–433, DOI: 10.1353/bhm.1998.0159.
- Kaptchuk, T.J. et al. 2008. Components of placebo effect: randomised controlled trial in patients with irritable bowel syndrome, *British Medical Journal*, 336(7651): 999–1003, DOI: 10.1136/bmj.39524.439618.25.
- Kleinman, A. 1997. *Writing at the margin: discourse between anthropology and medicine*. Berkeley and London: University of California Press.
- Kuriyama, S. 1995. Interpreting the history of bloodletting, *Journal of the History of Medicine and Allied Sciences*, 50(1): 11–46, DOI: 10.1093/jhmas/50.1.11.
- Kuriyama, S. 1999. *The expressiveness of the body and the divergence of Greek and Chinese medicine*. New York: Zone Books.
- Little P. et al. 2015. Randomised controlled trial of a brief intervention targeting predominantly non-verbal communication in general practice consultations, *British Journal of General Practice*, 65(635): e351–e356, DOI: 10.3399/bjgp15X685237.
- Lock, M. M. 1978. Scars of experience: the art of moxibustion in Japanese medicine and society, *Culture, Medicine and Psychiatry*, 2(2): 151–175, DOI: 10.1007/BF00054582.
- Lykiardopoulos, A. 1981. The evil eye: towards an exhaustive study, *Folklore*, 92(2): 221–230, DOI: 10.1080/0015587X.1981.9716210.
- Mercer, S.W., D.N. Blane and B. Dinesh Jani 2012. The role of empathy in therapy and the physician-patient relationship, *Forsch Komplementmed*, 19(5): 252-7, DOI: 10.1159/000342998.
- Mercer, S.W., and W.J. Reynolds 2002. Empathy and quality of care, *British Journal of General Practice: the Journal of the Royal College of General Practitioners*, 52 (Supplement): S9–S12, DOI: 10.1007/0-387-33608-7.
- Merleau-Ponty, M. 2002. The spatiality of one's own body and motility. In C. Smith (ed), *Phenomenology of Perception*. London; New York: Routledge, 112-70.
- Moerman, D.E. 2002. *Meaning, medicine and the placebo effect*, Cambridge: Cambridge University Press, DOI: 10.1017/CBO9780511810855.
- Moerman, D.E., and W.B. Jonas 2002. Deconstructing the placebo effect and finding the meaning response, *Annals of Internal Medicine*, 136(6): 471-6, DOI: 10.7326/0003-4819-136-6-200203190-00011.
- National Health Service. (2018) *Complementary and alternative medicine/ NHS* [Online]. Available at: <https://www.nhs.uk/conditions/complementary-and-alternative-medicine/> (Accessed: 10 August 2020)

- National Institute of Health. (2018) *Complementary, Alternative, or Integrative Health: What's In a Name?/ NIH* [Online]. Available at: <https://www.nccih.nih.gov/health/complementary-alternative-or-integrative-health-whats-in-a-name> (Accessed: 10 August 2020)
- Parkin, D. 2007. Wafting on the wind: smell and the cycle of spirit and matter, *Journal of the Royal Anthropological Institute*, 13(Supplement 1): S39–S53, DOI: 10.1111/j.1467-9655.2007.00408.x.
- Patel, R.S. et al. 2018. Factors related to physician burnout and its consequences: a review, *Behavioral Sciences*, 8(11): 98-104, DOI: 10.3390/bs8110098.
- Poirier, S. 2004. Ontology, ancestral order, and agencies among the Kukatja of the Australian Western Desert. In J. Clammer, S. Poirier and E. Schwimmer (eds.), *Figured Worlds*, Toronto etc.: University of Toronto Press, 58–82, DOI: 10.3138/9781442674899-006.
- Raftopoulos, L. 1983. Vascano: the Greek evil eye, *Lambda Alpha Journal*, 15(1/2): 32–51.
- Roussou, E. 2011a. Orthodoxy at the crossroads: popular religion and Greek identity in the practice of the evil eye, *Journal of Mediterranean Studies*, 20(1): 85–105.
- Roussou, E. 2011b. When soma encounters the spiritual. In A. Fedele and R.L. Blanes (eds.), *Encounters of body and soul in contemporary religious practices* (1st edn.), New York and Oxford: Berghahn Books, 133–150.
- Roussou, E. 2014. Believing in the supernatural through the 'evil eye': perception and science in the modern Greek cosmos, *Journal of Contemporary Religion*, 29(3): 425–438, DOI: 10.1080/13537903.2014.945726.
- Seremetakis, C. N. 1991. *The last word: women, death, and divination in inner Mani*. Chicago and London: The University of Chicago Press.
- Seremetakis, C. N. 2009. Divination, media, and the networked body of modernity, *American Ethnologist*, 36(2): 337–350, DOI: 10.1111/j.1548-1425.2009.01138.x.
- Shanafelt, T.D., et al. 2016. Relationship between clerical burden and characteristics of the electronic environment with physician burnout and professional satisfaction, *Mayo Clinic Proceedings*, 91(7):836-48, DOI: 10.1016/j.mayocp.2016.05.007.
- Souvlakis, N. 2020. A psychological ethnographic study of the Christian Orthodox understanding of evil eye and its effects on individuals' mental health and development of personhood in the contemporary Greek region of Corfu Island. PhD thesis, Durham University.
- Sullivan, M. D. 1993. Placebo controls and epistemic control in orthodox medicine, *Journal of Medicine and Philosophy*, 18(2): 213–231, DOI: 10.1093/jmp/18.2.213.
- Thirioux, B., F. Birault and N. Jaafari 2016. Empathy is a protective factor of burnout in physicians: new neuro-phenomenological hypotheses regarding empathy and sympathy in care relationship, *Frontiers in Psychology*, 7(763): 1-11, DOI: 10.3389/fpsyg.2016.00763.
- Veikou, C. 1998. *To kako mati: i kinoniki kataskevi tis optikis epikoinonias*. Athens: Ellinika Grammata.

- Wahlberg, A. 2008. Above and beyond superstition: western herbal medicine and the decriminalizing of placebo, *History of the Human Sciences*, 21(1): 77–101, DOI: 10.1177/0952695107086153.
- Waldram, J. B. 2000. The efficacy of traditional medicine: current theoretical and methodological issues, *Medical Anthropology Quarterly*, 14(4): 603–625, DOI: 10.1525/maq.2000.14.4.603.
- West, C.P., L.N. Dyrbye and T.D. Shanafelt 2018. Physician burnout: contributors, consequences and solutions, *Journal of Internal Medicine*, 283(6):516-29, DOI: 10.1111/joim.12752.
- Whyte, S.R., S. van der Geest and A. Hardon 2002. Mothers and children: the efficacies of drugs. In *Social Lives of Medicines*. Cambridge: Cambridge University Press, 23-36.
- Young, D. 2005. The smell of greenness: cultural synaesthesia in the Western Desert, *Etnofoor*, 18(1): 61–77, DOI: 10.2307/25758086.
- Zahavi, D. 2012. Empathy and mirroring: Husserl and Gallese. In R. Breuer and U. Melle *Life, Subjectivity, & Art*, Dordrecht: Springer, 217–254, DOI: 10.1007/978-94-007-2211-8-9.